

THIS OBJECTION SEEKS TO (I) DISALLOW AND EXPUNGE IN PART, (II) SUBORDINATE AND RECLASSIFY AS EQUITY IN PART, (III) REDUCE, AND (IV) RECLASSIFY, IN WHOLE OR IN PART, CERTAIN PROOFS OF CLAIM AND TO ALLOW SUCH CLAIMS, AS MODIFIED, WITH PROPER CLASSIFICATION AS PRIORITY OR UNSECURED GENERAL CREDITOR CLAIMS. PARTIES RECEIVING THIS NOTICE OF THE TRUSTEE'S TWO HUNDRED FIFTY-SIXTH OMNIBUS OBJECTION TO GENERAL CREDITOR CLAIMS SHOULD REVIEW THE OMNIBUS OBJECTION TO SEE IF THEIR NAME(S) OR CLAIM(S) ARE LOCATED IN THE OMNIBUS OBJECTION OR IN THE EXHIBITS ATTACHED THERETO TO DETERMINE WHETHER THIS OBJECTION AFFECTS THEIR CLAIM(S).

IF YOU HAVE QUESTIONS, PLEASE CONTACT THE TRUSTEE'S COUNSEL, KAREN M. CHAU, ESQ., AT (212) 837-6512.

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**UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK**

In re

LEHMAN BROTHERS INC.,

Debtor.

Case No. 08-01420 (SCC) SIPA

**NOTICE OF HEARING ON THE TRUSTEE'S TWO HUNDRED FIFTY-SIXTH
OMNIBUS OBJECTION TO GENERAL CREDITOR CLAIMS (EMPLOYEE CLAIMS)**

PLEASE TAKE NOTICE that on August 1, 2014, James W. Giddens (the "Trustee"), as trustee for the liquidation of the business of Lehman Brothers Inc. (the "Debtor" or "LBI"), under the Securities Investor Protection Act of 1970, as amended, 15 U.S.C. §§ 78aaa *et seq.* ("SIPA"), by and through his undersigned counsel, filed his two hundred fifty-sixth

omnibus objection to general creditor claims (the “Two Hundred Fifty-Sixth Omnibus Objection to General Creditor Claims”), and that a hearing to consider the Trustee’s Two Hundred Fifty-Sixth Omnibus Objection to General Creditor Claims will be held before the Honorable Shelley C. Chapman, United States Bankruptcy Judge, at the United States Bankruptcy Court, Alexander Hamilton Customs House, Courtroom 623, One Bowling Green, New York, New York 10004 (the “Bankruptcy Court”), on **September 9, 2014 at 10:00 a.m. (Prevailing Eastern Time)** (the “Hearing”).

PLEASE TAKE FURTHER NOTICE that responses, if any, to entry of the order must (i) be in writing; (ii) state the name and address of the responding party and nature of the claim or interest of such party; (iii) state with particularity the legal and factual bases of such response; (iv) conform to the Federal Rules of Bankruptcy Procedure and Local Bankruptcy Rules; (v) be filed with the Bankruptcy Court, together with proof of service, electronically, in accordance with General Order M-399 by registered users of the Court’s Electronic Case Filing system, and by all other parties in interest, on a 3.5 inch disk, compact disk, or flash drive, preferably in Portable Document Format (PDF), WordPerfect or any other Windows-based word processing format no later than **August 22, 2014 at 4:00 p.m. (Prevailing Eastern Time)** (the “Response Deadline”); and (vi) be served on (a) Hughes Hubbard & Reed LLP, One Battery Park Plaza, New York, New York, 10004, Attn: Meaghan C. Gragg, Esq.; (b) Securities Investor Protection Corporation, 805 Fifteenth Street, N.W., Suite 800, Washington, DC 20005, Attn: Kenneth J. Caputo, Esq.; (c) Weil Gotshal & Manges LLP, 767 Fifth Avenue, New York, New York 10153, Attn: Maurice Horwitz, Esq. and Lori R. Fife, Esq., with a courtesy copy to the chambers of the Honorable Shelley C. Chapman, United States Bankruptcy Court for the

Southern District of New York, One Bowling Green, New York, New York 10004, Courtroom
623.

PLEASE TAKE FURTHER NOTICE that if no responses are timely filed and served with respect to the Trustee's Two Hundred Fifty-Sixth Omnibus Objection to General Creditor Claims or any claim set forth thereon, the Trustee may, on or after the Response Deadline, submit to the Bankruptcy Court an order substantially in the form of the proposed order annexed to the Trustee's Two Hundred Fifty-Sixth Omnibus Objection to General Creditor Claims, which may be entered with no further notice or opportunity to be heard offered to any party.

Dated: New York, New York
August 1, 2014

HUGHES HUBBARD & REED LLP

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SOUTHERN DISTRICT OF NEW YORK**

In re:

LEHMAN BROTHERS INC.,

Debtor.

Case No. 08-01420 (SCC)

**THE TRUSTEE'S TWO HUNDRED FIFTY-SIXTH OMNIBUS OBJECTION
TO GENERAL CREDITOR CLAIMS (EMPLOYEE CLAIMS)**

THIS OBJECTION SEEKS TO (I) DISALLOW AND EXPUNGE IN PART, (II) SUBORDINATE AND RECLASSIFY AS EQUITY IN PART, (III) REDUCE, AND (IV) RECLASSIFY, IN WHOLE OR IN PART, CERTAIN PROOFS OF CLAIM AND TO ALLOW SUCH CLAIMS, AS MODIFIED, WITH PROPER CLASSIFICATION AS PRIORITY OR UNSECURED GENERAL CREDITOR CLAIMS. PARTIES RECEIVING THIS NOTICE OF THE TRUSTEE'S TWO HUNDRED FIFTY-SIXTH OMNIBUS OBJECTION TO GENERAL CREDITOR CLAIMS SHOULD REVIEW THE OMNIBUS OBJECTION TO SEE IF THEIR NAME(S) OR CLAIM(S) ARE LOCATED IN THE OMNIBUS OBJECTION OR IN THE EXHIBITS ATTACHED THERETO TO DETERMINE WHETHER THIS OBJECTION AFFECTS THEIR CLAIM(S).

**IF YOU HAVE QUESTIONS, PLEASE CONTACT THE TRUSTEE'S COUNSEL,
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TO THE HONORABLE SHELLEY C. CHAPMAN,
UNITED STATES BANKRUPTCY JUDGE:

James W. Giddens (the “Trustee”), as Trustee for the liquidation of the business of Lehman Brothers Inc. (the “Debtor” or “LBI”) under the Securities Investor Protection Act of 1970 as amended, 15 U.S.C. §§ 78aaa *et seq.* (“SIPA”),¹ by and through his undersigned counsel, respectfully represents as follows:

RELIEF REQUESTED

1. The Trustee files this two hundred fifty-sixth omnibus objection to general creditor claims (the “Two Hundred Fifty-Sixth Omnibus Objection to General Creditor Claims”) pursuant to section 502(b) of title 11 of the United States Code (the “Bankruptcy Code”), as made applicable to this proceeding pursuant to sections 78fff(b) and 78fff-1(a) of SIPA, Rule 3007(d) of the Federal Rules of Bankruptcy Procedure (the “Bankruptcy Rules”), and this Court’s order approving procedures for the filing of omnibus objections to general creditor claims filed in this SIPA proceeding (the “General Creditor Claim Objection Procedures Order,” ECF No. 5441), seeking to: (i) reduce, (ii) reclassify, in whole or in part, (iii) disallow and expunge in part, or (iv) subordinate and reclassify as equity in part, and to allow, as modified, each claim listed on Exhibit A with proper classification as priority or unsecured general creditor claims. The Trustee’s proposed order (the “Proposed Order”) is annexed hereto as Exhibit E.

2. Counsel for the Trustee has examined each of the proofs of claim identified on Exhibit A (collectively, the “Employee Claims” or the “Claims”) and has determined that (i) portions of certain of the Claims should be reduced or reclassified because the amounts claimed in the Claims do not accord with calculations based on LBI’s books and records (the “Books and

1. For convenience, subsequent references to SIPA will omit “15 U.S.C.”

Records”) or were asserted in the incorrect priority; (ii) portions of certain of the Claims should be disallowed and expunged on the grounds that LBI has no liability for such claims; and (iii) portions of certain of the Claims should be reclassified as equity interests pursuant to section 510(b) of the Bankruptcy Code because the claims seek to recover based on the right to receive accrued equity in Lehman Brothers Holdings Inc. (“LBHI”), an affiliate of LBI.

3. The Trustee therefore respectfully requests that the Employee Claims listed on Exhibit A be reduced, reclassified to unsecured status in whole or in part, disallowed and expunged in part, or subordinated and reclassified as equity in part and allowed as modified, as indicated on Exhibit A.

JURISDICTION AND VENUE

4. Following removal to this Court for all purposes as required for SIPA cases by section 78eee(b)(4) of SIPA, this Court has “all of the jurisdiction, powers, and duties conferred by [SIPA] upon the court to which application for the issuance of the protective decree was made.” 15 U.S.C. § 78eee(b)(4).

5. Venue is proper in this Court pursuant to SIPA section 78eee(a)(3) and 15 U.S.C. section 78aa.

BACKGROUND

6. On September 19, 2008 (the “Filing Date”), the Honorable Gerard E. Lynch, United States District Court, Southern District of New York, entered the Order Commencing Liquidation of LBI (the “LBI Liquidation Order,” ECF No. 1) pursuant to the provisions of SIPA in the case captioned *Securities Investor Protection Corporation v. Lehman Brothers Inc.*, Case No. 08-CIV-8119 (GEL). The LBI Liquidation Order, *inter alia*, (i) appointed the Trustee for the liquidation of the business of LBI pursuant to section 78eee(b)(3) of SIPA; and (ii) removed

the case to this Court for all purposes as required for SIPA cases by section 78eee(b)(4) of SIPA, in the case captioned *In re Lehman Brothers Inc.*, Case No. 08-01420 (JMP).

7. On November 7, 2008, the Court entered the Order Approving Form and Manner of Publication and Mailing of Notice of Commencement; Specifying Procedures and Forms for Filing, Determination, and Adjudication of Claims; Fixing a Meeting of Customers and Other Creditors; and Fixing Interim Reporting Pursuant to SIPA (the “Customer Claims Process Order,” ECF No. 241). Beginning on December 1, 2008, consistent with SIPA section 78fff-2(a)(1), the Trustee mailed more than 905,000 claims packages with filing information to former LBI customers and other potential claimants (the “Claims Process Notice”) and posted claims filing information on the Trustee’s website (www.lehmantrustee.com) and SIPC’s website (www.sipc.org). The Trustee also published notice of the claims process in The New York Times, The Wall Street Journal and The Financial Times.

8. Pursuant to SIPA section 78fff-2(a)(3) and the Customer Claims Process Order, customer claims seeking maximum protection under SIPA must have been received by the Trustee on or before January 30, 2009. All customer claims and general creditor claims must have been received by the Trustee by June 1, 2009 and no claims of any kind will be allowed unless received by the Trustee on or before June 1, 2009 (the “Bar Date”). In addition to the Bar Date, on September 19, 2013, the Bankruptcy Court entered an order (the “Administrative Bar Date Order”) that established October 31, 2013 (the “Administrative Bar Date”) as the deadline to file a proof of claim for administrative expense claims against the LBI estate, as further described in the Administrative Bar Date Order, with respect to such administrative expenses arising between September 19, 2008 and August 31, 2013. The Administrative Bar Date has

now passed. A copy of the Customer Claims Process Order was made publicly available at www.lehmantrustee.com.

9. In accordance with the Customer Claims Process Order, in cases where the Trustee denied a claim for protection as a customer and converted the claim to a general creditor claim, the Trustee notified the claimant consistent with the procedures set forth in the Customer Claims Process Order. The claimant was afforded the opportunity to object and have the matter heard by the Court if the claimant was aggrieved by the Trustee's denial of customer treatment and conversion of the claim to a general creditor claim. If a claimant did not object to the Trustee's conversion of the claim consistent with the procedures set forth in the Customer Claims Process Order, the Trustee's conversion of the claim to a general creditor claim became final. No determination was made as to the validity or allowed amount of such converted and reclassified claims.

10. The Bankruptcy Rules' Official Form 10 (the "Claim Form"), the standardized proof of claim form which was approved for use in this case in the Customer Claims Process Order, requires general creditor claimants to "[a]ttach redacted copies of any documents that support the claim." (Claim Form at 1.) Furthermore, instructions included with the Claim Form under the heading "Items to be completed in Proof of Claim form" required creditors to "attach to [the] proof of claim form redacted copies documenting the existence of the debt and of any lien securing the debt." (*Id.* at 2.) The Claim Form also instructed claimants to explain the absence of documentation "[i]f the documents are not available." (*Id.* at 1.) The Trustee's website allowed claimants filing electronically to upload documents as part of their claim submission and thereby comply with the instructions to include supporting documentation set

forth in the Claim Form. The Customer Claims Process Order also put claimants on notice that they should submit supporting documentation with their claims.

11. On November 15, 2012, the Court entered the General Creditor Claim Objection Procedures Order (ECF 5441), which authorizes the Trustee, among other things, to file omnibus objections to no more than 200 general creditor claims at a time, on various grounds, including the grounds set forth in Bankruptcy Rule 3007(d), and additional grounds including that the claims subject to the omnibus objection (i) seek recovery of amounts for which LBI is not liable, (ii) were incorrectly classified, or (iii) do not include sufficient documentation to ascertain the validity of the claim.

12. On May 8, 2014, the Trustee filed the Motion for an Order Pursuant to Section 105(a), 502(a), 502(c) and 726 of the Bankruptcy Code and Bankruptcy Rule 3009 (I) Establishing a Final Reserve for Secured, Administrative and Priority Claims, (II) Allowing Certain Secured, Administrative and Priority Claims, (III) Authorizing the Trustee to Satisfy Allowed Secured, Administrative and Priority Claims, and Related Relief (the “Secured and Priority Claims Reserve Motion,” ECF No. 8885) and on July 2, 2014, the Court entered an order approving the Secured and Priority Claims Reserve Motion (the “Secured and Priority Claims Reserve Order,” ECF No. 9273). Pursuant to the Secured and Priority Claims Reserve Order, the Trustee established a Secured and Priority Claims Reserve of \$612 million, of which approximately \$242 million is for Allowed Secured and Priority Claims, and each of the

unresolved Secured and Priority Claims was capped in the amounts provided in the schedules attached to the Secured and Priority Claims Reserve Order.²

13. On June 26, 2014, the Trustee filed the Motion for an Order Pursuant to Sections 105(a), 502(a), 502(c) and 726 of the Bankruptcy Code and Bankruptcy Rule 3009 (I) Capping the Maximum Allowable Amounts, and Establishing an Interim Distribution Fund, for Unsecured Claims, (II) Allowing Certain Unsecured Claims, (III) Authorizing the Trustee to Make a First Interim Distribution to Allowed Unsecured Creditors with a Record Date of July 15, 2014, and Related Relief (the “Unsecured Claims Reserve Motion,” ECF 9246), and on July 30, 2014, the Court entered an order approving the Unsecured Claims Reserve Motion (the “Unsecured Claims Reserve Order,” ECF 9520). Pursuant to the Unsecured Claims Reserve Order, the Trustee established the Interim Distribution Fund of \$3 billion or more for the purpose of making a first interim distribution to the holders of allowed unsecured claims and maintaining *pro rata* reserves for unresolved claims. Further, the Unsecured Claims Reserve Order capped the maximum potentially allowable unsecured amounts of the unresolved claims, and barred further amendments increasing such amounts.

THE CLAIMS

14. The Claims listed on Exhibit A annexed hereto assert claims for one or more of the following:

- Unpaid commissions earned prior to the Filing Date arising out of employment with LBI which should be reduced because the amounts claimed do not accord with calculations based on the Books and Records (the “Commissions Claims”).

2. Unless otherwise defined, all defined terms in this paragraph have the meaning ascribed to them in the Secured and Priority Claims Reserve Motion.

- Severance payments based upon pre-Filing Date severance agreements with LBI which should be reduced because they miscalculate the amount of severance owed or fail to account for partial severance payments that the claimant received from LBI prior to the Filing Date (the “Severance Claims”).
- Payment of amounts on account of estimated hypothetical tax withholdings for former LBI employees working abroad which lack sufficient documentation to support the amount asserted and/or are not supported by the Books and Records (the “Hypo-Tax Claims”).
- Deferred compensation payments based upon a pre-Filing Date deferred compensation agreement with LBI which should be reduced because they miscalculate the amount of deferred compensation owed (the “Deferred Compensation Claim”).
- Payments of amounts on account of compensation which must be capped pursuant to Bankruptcy Code section 502(b)(7) (the “Capped Claims”).
- Entitlement to priority or secured status to which the claimants are not entitled because the claims do not meet the statutory requirements for priority or secured status under Bankruptcy Code sections 506(a) and 507(a), or are in excess of the statutory cap under section 507(a)(4)(A) (the “Misclassified Claims”).
- Additional grounds for recovery which fail to comply with the instructions included with the official proof of claim form (the “Claim Form”) and Bankruptcy Rule 3001(c), as it was submitted without sufficient supporting documentation to determine the validity of the claim (the “Insufficient Documentation Claims”).
- Equity interests in LBHI purportedly owned in the form of restricted stock units, contingent stock awards, contingent equity awards, stock options, or other equity-related compensation (together, the “Equity Awards”), all of which were granted to employees of LBI and other Lehman entities as part of their compensation, and provided employees with the right to shares of LBHI common stock on a future date upon the satisfaction of certain conditions (the “Equity Award Claims”).
- The alleged right to the delivery of Equity Awards as of the Filing Date (the “Accrued Equity Claims”).
- The alleged right to the portion of a claimant’s bonus which was to be paid in Equity Awards (the “Bonus Equity Claims”).

Exhibit A specifies which of the arguments set forth below applies as to each of the Employee Claims.

**THE CLAIMS SHOULD BE REDUCED OR RECLASSIFIED AND ALLOWED,
DISALLOWED AND EXPUNGED, AND/OR RECLASSIFIED AS EQUITY**

15. A filed proof of claim is “deemed allowed, unless a party in interest . . . objects.” 11 U.S.C. § 502(a). If an objection refuting at least one of the claim’s essential allegations is asserted, the claimant has the burden to demonstrate the validity of the claim. *See In re Oneida Ltd.*, 400 B.R. 384, 389 (Bankr. S.D.N.Y. 2009), *aff’d sub nom. Peter J. Solomon Co. v. Oneida Ltd.*, No. 09 Civ. 2229 (DC), 2010 WL 234827 (S.D.N.Y. Jan. 22, 2010); *In re Adelphia Commc’ns Corp.*, Ch. 11 Case No. 02-41729 (REG), 2007 Bankr. LEXIS 660, at *15 (Bankr. S.D.N.Y. Feb. 20, 2007); *In re Rockefeller Ctr. Props.*, 272 B.R. 524, 539 (Bankr. S.D.N.Y. 2000). Section 502(b)(1) of the Bankruptcy Code provides, in relevant part, that a claim may not be allowed to the extent that “such claim is unenforceable against the debtor and property of the debtor, under any agreement or applicable law.” 11 U.S.C. § 502(b)(1).

I. The Commissions Claims, Severance Claims, Hypo-Tax Claims, And Deferred Compensation Claim Should Be Reduced And Allowed In Such Modified Amounts.

16. Section 502(b) of the Bankruptcy Code provides, in relevant part, that a court should determine the amount of a claim subject to an objection “as of the date of the filing of the petition, and shall allow such claim in such amount,” and that a claim may not be allowed to the extent that “such claim is unenforceable against the debtor and property of the debtor, under any agreement or applicable law.” 11 U.S.C. § 502(b). The General Creditor Claim Objection Procedures Order authorizes the Trustee to file omnibus objections “seeking reduction . . . [on the grounds that] the amount claimed contradicts LBI’s books and records; provided that the Trustee will include the amount of such General Creditor Claim, if any, reflected in LBI’s books and records.” (General Creditor Claim Objection Procedures Order at 2.)

A. The Commissions Claims Should Be Reduced.

17. Based on analysis by the Trustee's professionals of each of the Commissions Claims listed on Exhibit A, certain information from the LBI general claims register as maintained by the Trustee's claims agent, certain information from the Books and Records, and any other available information, the Trustee has determined that the Commissions Claims must be reduced because these Claims miscalculate the amount of commissions owed based on the Books and Records or, when the Books and Records did not indicate an accrued liability owed to the claimants, exceed a reasonable estimate of the amount of commissions owed based on available Books and Records information and do not provide information that would support liability on the part of LBI for these excessive amounts.

18. The Trustee's counsel also has subtracted the amount of the commissions that were to be paid in Equity Awards in accordance with LBI's equity award program in effect as of 2008, based on the proof of claim filed with each Commissions Claim, including the terms of any employment contracts or compensation statements attached to the Claims, certain of the Books and Records, and LBI's 2008 Equity Award Schedule for Production-Based Employees. (See 2008 Equity Award Program, attached hereto as Exhibit B, Ex. B.) As described further in Section V.C, these portions of the Claims should be subordinated and reclassified as equity pursuant to section 510(b) of the Bankruptcy Code, as made applicable to this proceeding pursuant to sections 78fff(b) and 78fff-1(a) of SIPA.

19. The amounts listed for the Commissions Claims on Exhibit A in the column entitled "*Claim as Modified*" and in the row denoted with the lettered symbol "(T)" are calculated by the Trustee's professionals and represent the amounts reflected in the Books and Records or a reasonable estimate of the value of the claims based on the Books and Records. Accordingly, pursuant to Bankruptcy Code sections 502, the Trustee requests that the Court

reduce each Commissions Claim to the amount listed on Exhibit A in the column entitled “*Claim as Modified*,” and allow each Commissions Claim to the extent of such amount.

B. The Severance Claims Should Be Reduced.

20. Based on analysis by the Trustee’s professionals of each of the Severance Claims, certain information from the LBI general claims register as maintained by the Trustee’s claims agent, and certain information from the Books and Records, the Trustee has determined that the Severance Claims on Exhibit A must be reduced because the Severance Claims miscalculate the amount of severance owed or fail to account for partial severance payments that the claimant received from LBI prior to the Filing Date.³

21. The amounts listed for the Severance Claims on Exhibit A in the column entitled “*Claim as Modified*” and in the row denoted with the lettered symbol “(T)” are calculated by the Trustee’s professionals and represent the amounts reflected in the Books and Records.⁴

Accordingly, pursuant to Bankruptcy Code sections 502, the Trustee requests that the Court

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3. Certain of the Severance Claims assert claims for employee contributions to health insurance premiums paid by claimants that would have been deducted from the claimants’ regular severance payments had those payments not been suspended. As these amounts would have been paid by the Severance Claimants and deducted from the severance payments owed, these contributions are fully included in the amount allowed for each Severance Claim. To the extent that any of the Severance Claims seeks to recover employer contributions to health insurance premiums owed under the LBHI Group Benefits Plan (the “Holdings Benefits Plan”), LBI is not a proper party in an action to recover these benefits and therefore is not liable for such loss of coverage. (See LBHI Group Benefits Plan Summary Plan Description 124-25, attached hereto as Exhibit D (showing The Holdings Benefit Plan is a welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 (“ERISA”) sponsored by LBHI and administered by the Employee Benefits Plans Committee of Lehman Brothers Holdings Inc.) It is clear from the plan documents that LBI was not designated as plan administrator and was not a plan trustee. (LBHI Group Benefits Plan Summary Plan Description 125 (designating the Employee Benefit Plans Committee of Lehman Brothers Holdings Inc. as the Plan Administrator for certain benefit plans, and designating various other parties not including LBI as Plan Administrators for all other benefit plans).) When a plan designates a different party as plan administrator, a non-trustee, including an employer, cannot be held liable for benefits due under the plan. *Crocco v. Xerox Corp.*, 137 F.3d 105, 107-08 (2d Cir. 1998) (rejecting attempt to recover plan benefits from employer as “de facto administrator”).
4. As discussed in Exhibit A, certain of the Severance Claims also assert claims for additional allowable items (the “Allowable Portions”). The amounts listed in the column entitled “*Claim as Modified*” thus includes both the amounts due to the claimants for the Severance Claims and the amounts owed for the Allowable Portions, as determined by the Trustee’s counsel.

reduce each Severance Claim to the amount listed on Exhibit A in the column entitled “*Claim as Modified*,” and allow each such Severance Claim to the extent of such amount.

C. The Hypo-Tax Claims Should Be Reduced.

22. The Hypo-Tax Claims seek payment in whole or in part of amounts on account of estimated hypothetical tax withholdings for former LBI employees working abroad. Such estimated hypothetical tax withholdings were deducted from the compensation of employees on assignment abroad to pay such employees’ U.S. tax obligations pursuant to LBI’s Tax Equalization Policy.

23. Based on analysis by the Trustee’s counsel of each of the Hypo-Tax Claims, certain information from the LBI general claims register as maintained by the Trustee’s claims agent, and certain information from the Books and Records, the Trustee has determined that the Hypo-Tax Claims must be reduced because they lack sufficient documentation to support the amount asserted and/or are not supported by the Books and Records.

24. The amounts listed for the Hypo-Tax Claims on Exhibit A in the column entitled “*Claim as Modified*” and in the row denoted with the lettered symbol “(T)” are calculated by the Trustee’s professionals and represent the amounts reflected in the Books and Records.⁵ Accordingly, pursuant to Bankruptcy Code section 502, the Trustee requests that the Court reduce each Hypo-Tax Claim to the amount listed on Exhibit A in the column entitled “*Claim as Modified*,” and allow each Hypo-Tax Claim to the extent of such amount.

5. As discussed in Exhibit A, certain of the Hypo-Tax Claims also assert claims for additional Allowable Portions. The amounts listed in the column entitled “*Claim as Modified*” thus includes both the amounts due to the claimants for the Hypo-Tax Claims and the amounts owed for the Allowable Portions, as determined by the Trustee’s counsel.

D. The Deferred Compensation Claim Should Be Reduced.

25. Based on analysis by the Trustee's counsel of the Deferred Compensation Claim, the terms of the deferred compensation agreement attached thereto, statements, correspondence, and other documents filed in connection thereto, and based on analysis by the Trustee's counsel of certain information from the LBI general claims register as maintained by the Trustee's claims agent, and certain information from the books and records of the LBI estate, the Trustee has identified the Deferred Compensation Claim as a claim that must be reduced because the Deferred Compensation Claim miscalculates the amount of deferred compensation owed.

26. When a claim relates to an interest-bearing debt, such as a deferred compensation account, no interest unmatured as of the date of petition should be included in the value of the claim. 11 U.S.C. § 502(b) (“[I]f [an] objection to a claim is made, the court . . . shall determine the amount of such claim . . . as of the date of the filing of the petition.”); *see also In re Oakwood Homes Corp.*, 449 F.3d 588, 599 (3d Cir. 2006); *accord In re Thomson McKinnon Sec., Inc.*, 149 B.R. 61, 75 (Bankr. S.D.N.Y. 1992) (holding that discounting to present value is necessary for deferred compensation claims). In order to determine the value of the Deferred Compensation Claim as of the Filing Date, the Trustee's counsel calculated interest on the value of the account as of the most recent available statement of account, using the rate of interest and calculation methods applied to the account by LBI. The Trustee's counsel continued LBI's practice of calculating interest on a monthly basis and included pro rata interest for September 2008.

27. The amounts listed for the Deferred Compensation Claim on Exhibit A in the column entitled “*Claim as Modified*” and in the row denoted with the lettered symbol “(T)” represents the amount of the Deferred Compensation Claim, as determined by the Trustee's counsel based on LBI's books and records and documentation attached to the Deferred Compensation Claim, and in accordance with Bankruptcy Code section 502(b)(2). The holder of

the Deferred Compensation Claim should not be allowed to recover more than the value of his claim. Accordingly, in order to properly reflect the accurate value of this claim, the Trustee requests that the Court reduce the Deferred Compensation Claim to the amount listed on Exhibit A in the column entitled “*Claim as Modified*,” and allow the Deferred Compensation Claim in such modified amount.

II. The Capped Claims Should Be Capped In Accordance With Bankruptcy Code Section 502(b)(7).

28. Both of the Capped Claims assert claims for cash compensation allegedly owed pursuant to Claimant’s employment contracts (the “Employment Agreements”). Each of the Employment Agreements provided for annual compensation and for four equal annual payments (the “Special Cash Payments”), with the first payment due on the first anniversary of the claimant’s employment. Based upon analysis of the books and records of the LBI estate, the employment of both of the claimants ended on or about January 12, 2008. Following the termination of their employment, both claimants received one of the four Special Cash Payments on or about the first anniversary of his employment. The Capped Claims assert claims for the outstanding Special Cash Payments.

29. Section 502(b)(7) of the Bankruptcy Code provides, in relevant part, that a claim for “damages resulting from the termination of an employment contract” may not be allowed to the extent that such claim exceeds “the compensation provided by such contract . . . for one year following . . . the date on which the employer directed the employee to terminate . . . performance under such contract.” 11 U.S.C. 502(b)(7). The section 502(b)(7) cap on damages applies to “all employment contract termination claims, regardless of whether: (1) the claim has been reduced to judgment; (2) there is any connection between the employee's termination and the debtor's financial problems; and (3) a number of years has passed between the employee's

termination and the debtor's filing of the bankruptcy petition.” *Anthony v. Interform Corp.*, 96 F.3d 692, 697 (3d Cir.1996). In short, “section 502(b)(7) limits claims by a terminated employee for future compensation to one year’s pay.” *Howell v. F.D.I.C.*, 986 F.2d 569, 572 (1st Cir. 1993).

30. Each of the Capped Claims is based on the alleged right to damages resulting from the termination of an Employment Agreement, which is an “employment contract” under section 502(b)(7). *See In re FairPoint Commc’ns, Inc.*, 445 B.R. 271, 273 (Bankr. S.D.N.Y. 2011) (defining an “employment contract” under section 502(b)(7) as a writing that “establishes the terms and conditions of an employment relationship”). Therefore, under section 502(b)(7), each of the Capped Claims must be capped at the amount of one year’s compensation under the applicable Employment Agreement.

31. The amounts listed for the Capped Claims on Exhibit A in the column entitled “*Claim as Modified*” and in the row denoted with the lettered symbol “(T)” represents the amount of one year’s compensation under the applicable Employment Agreement, as determined by the Trustee’s counsel based on the Employment Agreements and LBI’s books and records, and in accordance with Bankruptcy Code section 502(b)(7). Accordingly, pursuant to Bankruptcy Code section 502, the Trustee requests that the Court reduce each Capped Claim to the amount listed on Exhibit A in the column entitled “*Claim as Modified*,” and allow each such Capped Claim to the extent of such amount.

III. The Misclassified Claims Should Be Reclassified, In Whole Or In Part, As Priority Or Unsecured General Creditor Claims.

32. The Misclassified Claims include claims by former employees which assert priority under Bankruptcy Code section 507(a)(4)(A) or under Bankruptcy Code section 507(a)(8), or which assert secured status under Bankruptcy Code section 506(a)(1). Based on

analysis by the Trustee's counsel of each of the Misclassified Claims, the Trustee has determined that the Misclassified Claims must be reclassified, in whole or in part, to general unsecured status.

33. Certain of the Misclassified Claims must be reclassified, in whole or in part, from priority to general unsecured status because they claim priority under Bankruptcy Code section 507(a)(4)(A) for amounts in excess of the statutory cap or amounts earned more than 180 days prior to the Filing Date. *See* 11 U.S.C. § 507(a)(4)(A). According to Bankruptcy Code section 507(a)(4)(A), claims of former employees of a debtor for “wages, salaries, or commissions, including vacation, severance, and sick leave pay” are entitled to priority status, but only up to \$10,950,⁶ and only if earned within the 180 days leading up to the commencement of the SIPA Proceeding. 11 U.S.C. § 507(a)(4)(A). Claims for such wages, salaries, or commissions earned more than 180 days before the commencement of the SIPA Proceeding or in excess of the \$10,950 statutory cap must be classified as general unsecured claims, with no priority, administrative, or secured status. *In re LandAmerica Fin. Group, Inc.*, 435 B.R. 343, 352 (Bankr. E.D. Va. 2010) *aff'd sub nom. Matson ex rel. LandAmerica Fin. Group, Inc. v. Alarcon*, 651 F.3d 404, 410 (4th Cir. 2011) (holding that section 507(a)(4) claims earned in excess of the statutory cap are general unsecured claims); *In re Powermate Holding Corp.*, 394 B.R. 765, 773 (Bankr. D. Del. 2008) (stating that claims in excess of the section 507(a)(4) statutory cap are general unsecured claims); *In re Chicago Lutheran Hosp. Ass'n*, 75 B.R. 854, 856 (Bankr. N.D.

6. The amount of the employee compensation priority has been changed periodically for cases filed subsequent to the change in question. This SIPA Proceeding was commenced on September 19, 2008, and therefore the applicable amount of the employee compensation priority in this proceeding is \$10,950. *See* Bankruptcy Code § 104(a); Revision of Certain Dollar Amounts in the Bankruptcy Code Prescribed Under Section 104(a) of the Code, 75 Fed. Reg. 8,747-01 (Feb. 25, 2010); Revision of Certain Dollar Amounts in the Bankruptcy Code Prescribed Under Section 104(A) of the Code, 78 Fed. Reg. 12,089-01 (Feb. 21, 2013).

Ill. 1987) (explaining that claims in excess of the statutory cap “are nothing more than general unsecured claims, entitled to no priority whatsoever”); *In re Chateaugay Corp.*, 115 B.R. 760, 784 (Bankr. S.D.N.Y. 1990) *opinion withdrawn and vacated on other grounds*, 89 CIV. 6012 (KTD), 1993 WL 388809, at *1-3 (S.D.N.Y. June 16, 1993) (holding that priority claims must be reclassified as general unsecured claims to the extent that they do not conform to the requirements of section 507(a)(4)). Accordingly the Misclassified Claims which claim priority for amounts in excess of \$10,950 or amounts earned more than 180 days prior to the Filing Date should be reclassified, in whole or in part, to general unsecured status.

34. In addition, four of the Misclassified Claims, numbered 3268, 7000214, 7001032, and 7001109, assert priority status pursuant to section 507(a)(8). Each of these claims should be reclassified to general unsecured claims because section 507(a)(8) applies only to governmental units, not individuals. *See* 11 U.S.C. § 507(a)(8) (providing that “allowed unsecured claims of *governmental units*” are entitled to priority for certain delineated tax obligations (emphasis added)); *see also*, *In re Sarnovsky*, 436 B.R. 461, 464 (Bankr. N.D. Ohio 2010); *In re Oliver*, No. 13-10279-7, 2014 WL 2601977, *3 (Bankr. W.D. Wis. June 10, 2014); *In re Johnson*, A10-4005, 2010 WL 4115373, *2-3 (Bankr. D. Neb. Oct. 19, 2010). The term “governmental unit” does not include private individuals. *Id.* Instead, it is defined as the “United States; State; Commonwealth; District; Territory; municipality; foreign state; department, agency or instrumentality of the United States . . . , a State, a Commonwealth, a District, Territory, a municipality, or a foreign state; or other foreign or domestic government.” 11 U.S.C. § 101(27). By contrast, the term “person” specifically excludes “governmental units” from its definition except for certain limited exceptions not relevant here. *See* 11 U.S.C. § 101(41) (“The term ‘person’ includes individual, partnership, and corporation, but does not include governmental

unit . . .”). Accordingly, since these Misclassified Claims are asserted by individual persons, not governmental units, they are not entitled to priority status and should be reclassified to general unsecured status.

35. Two of the Claims, numbered 7001532 and 6075, assert entitlement to secured status under the Bankruptcy Code, but do not provide any supporting explanation or documentation. *See* 11 U.S.C. § 506(a)(1). Therefore, the Claims numbered 77001532 and 6075 must be reclassified from secured to unsecured status.

36. One of the Claims, numbered 4698, asserts entitlement to secured status under the Bankruptcy Code on the basis of an alleged lien on corporate owned life insurance (“COLI”) policies which the Claim asserts were purchased by LBI in order to recoup the costs of operating a deferred compensation plan. This assertion of secured status is directly contradicted by documentation attached to this claim, which provides that payments made under the deferred compensation plan agreement are unsecured obligations only. Nowhere in the deferred compensation plan agreement is there any language which states or implies that the claimant possess a security interest in any asset of LBI.⁷ As the claimant listed on the claim numbered 4698 has submitted no other documents that evidence the perfection of a security interest in any property of LBI, the claim numbered 4698 must be reclassified from a secured to unsecured status.

7. It is well established that the use, by the employer, of COLI policies to recoup the liabilities of a deferred compensation plan does not alter the explicit terms of the deferred compensation contract, and does not create a separate *res* that the Claimants may look to in order to satisfy their claims. *Demery v. Extebank Deferred Compensation Plan (B)*, 216 F.3d 283, 287 (2d Cir. 2000) (where the terms of the plan give the claimants only those rights possessed by any other unsecured creditor, use of COLI policies did not give claimants special rights); *Miller v. Heller*, 915 F. Supp. 651, 660 (S.D.N.Y. 1996) (“Thus, the fact that plaintiffs actually looked to the policies as security for deferred compensation cannot defeat the intention of the parties that is unambiguously expressed by the language of the two agreements.”). *See also In re IT Group, Inc.*, 448 F.3d 661 (3rd Cir. 2006); *Reliable Home Health Care Inc. v. Union Central Insurance Co.*, 295 F.3d 505 (5th Cir. 2002); *Belsky v. First Nat. Life Ins. Co.*, 818 F.2d 661 (8th Cir. 1987).

37. Accordingly, pursuant to Bankruptcy Code sections 502, 507(a)(4)(A), 507(a)(8), and 506(a)(1), the Trustee requests that the Court reclassify the Misclassified Claims to the priority status listed on Exhibit A in the column entitled “*Claim as Modified*,” and allow the Misclassified Claims as modified, with proper classification as priority or unsecured general creditor claims.

IV. The Insufficient Documentation Claims Should Be Disallowed And Expunged.

38. The Trustee’s professionals have determined that the portions of the Employee Claims that constitute Insufficient Documentation Claims should be disallowed and expunged on the basis that they do not include sufficient information for the Trustee to evaluate the merits and validity of such claims.

39. The Trustee’s counsel contacted the claimants listed on each of the Insufficient Documentation Claims to request information or documentation in support of their claims, and provided each claimant a period of at least seven calendar days (the “Response Period”) to provide such information or documentation. The Trustee’s counsel contacted the claimants by mail, electronic mail, or telephone, or a combination thereof. The claimants either (i) did not provide the requested additional information or documentation within the requested time frame, and have not provided additional information or documentation in support of their claims to date; or (ii) provided additional information or documentation which was still insufficient for the Trustee to evaluate the merits and validity of portions of their claims. None of the claimants has requested an extension of the Response Period to provide the Trustee additional information or supporting documentation. The Insufficient Documentation Claims do not constitute valid *prima facie* claims.

40. Bankruptcy Rule 3001(c) requires that “[w]hen a claim, or interest in property of the debtor securing the claim, is based on a writing, the original or a duplicate shall be filed with

the proof of claim.” Fed. R. Bankr. P. 3001(c). Claims filed in accordance with the rules “shall constitute *prima facie* evidence of the validity and amount of the claim.” Fed. R. Bankr. P. 3001(f); *see In re Oneida Ltd.*, 400 B.R. at 389; *see also In re MF Global Holdings Ltd.*, Case No. 11-15059 (MG), 2012 WL 5499847 (Bankr. S.D.N.Y. Nov. 13, 2012). However, if a claim fails to comply with the requirements of Bankruptcy Rule 3001, it is not entitled to *prima facie* validity. *Ashford v. Consol. Pioneer Mortg. (In re Consol. Pioneer Mortg.)*, 178 B.R. 222, 226 (9th Cir. BAP 1995) (holding that, as the claimants failed to comply with Rule 3001(c), their claim could not constitute *prima facie* evidence of validity under Rule 3001(f)), *aff’d sub nom. In re Consol. Pioneer Mortg. Entities*, 91 F.3d 151 (9th Cir. 1996). Further, this Court and others in the Second Circuit have held that “claims can be disallowed for failure to support the claim with sufficient evidence . . . because absent adequate documentation, the proof of claim is not sufficient for the objector to concede the validity of a claim.” *In re Residential Capital, LLC*, No.12-12020 (MG), 2013 WL 5524728, at *4 (Bankr. S.D.N.Y. Oct. 4, 2013) (upholding Debtor’s objection to claim on the ground that claimants failed to submit sufficient documentation and, therefore, did not meet their *prima facie* burden) (citation omitted); *In re Minbatiwalla*, 424 B.R. 104, 119 (Bankr. S.D.N.Y. 2010); *accord In re Porter*, 374 B.R. 471, 479-80 (Bankr. D. Conn. 2007).

41. Therefore, the Trustee requests that the Court disallow and expunge the portions of the Claims that constitute Insufficient Documentation Claims, as indicated on Exhibit A.

V. The Equity Awards Claims Should Be Disallowed And Expunged And The Accrued Equity Claims And Bonus Equity Claims Should Be Reclassified As Equity Interests And Subordinated.

A. The Equity Awards

42. Prior to the Filing Date, employees of LBI and other Lehman entities received a portion of their compensation in the form of Equity Awards. The amount of compensation paid

in the form of Equity Awards was determined based on the employee's position or title and total compensation for the year. In the case of bonus-eligible employees, Equity Awards were granted as a component of the year-end bonus. In the case of production-based employees, whose level of compensation was dependent on their level of production, the right to Equity Awards accrued on a monthly basis in amounts in accordance with a projection of each employee's total yearly compensation based on the employee's monthly production. These accrued Equity Awards then were granted concurrently with the grant of year-end bonuses. (*See* 2007 Equity Award Program, attached hereto as Exhibit C; 2008 Equity Award Program.)

43. Each of the Equity Awards Claims was filed by a former employee of LBI or another Lehman entity based on Equity Awards which already had been granted prior to the Filing Date. The Accrued Equity Claims each were filed by former production-based employees based on alleged rights to Equity Awards which had accrued pursuant to their employment but which had not yet been granted as of the Filing Date. The Bonus Equity Claim was filed by a former employee based on the alleged right to the portion of the claimant's bonus which was to be paid in Equity Awards.⁸

8. The portions of the Claim which relate to the segment of the claimant's bonuses which was to be paid in cash should be allowed as listed in Exhibit A for the Bonus Equity Claim in the column entitled "*Claim as Modified*" and in the row denoted with the lettered symbol "(T)."

The Trustee's counsel calculated the amount of the bonus that was to be paid in Equity Awards in accordance with LBI's equity award program in effect as of 2008, based on the proof of claim filed with each Bonus Equity Claim, including the terms of any severance contract attached to the claim, certain of the Books and Records, and LBI's 2008 Equity Award Schedule for Bonus-Eligible Employees. (*See* 2008 Equity Award Program, Ex. B.)

B. The Equity Awards Claims Should Be Disallowed And Expunged.

44. Based on analysis by the Trustee's counsel of the Equity Awards Claims and other relevant documents and materials,⁹ the Trustee has identified the Equity Awards Claims as claims for which LBI is not liable, as the Equity Awards Claims seek recovery of equity interests (owned in the form of Equity Awards) in LBHI.

45. The holders of the Equity Awards Claims fail to articulate any legal or factual justification for asserting a claim against LBI. The Equity Awards gave claimants the right to acquire stock in LBHI, not LBI, and the Equity Awards Claims do not give rise to a claim against LBI.¹⁰ If the Equity Awards Claims remain on the claims register, parties who do not

9. Documents reviewed by the Trustee's counsel include agreements governing the Equity Awards, plans and prospectus governing the use of Equity Awards by LBI and other Lehman entities, and minutes of the committee responsible for approving the grant of and plans governing the Equity Awards.

10. Even if the Equity Awards were to have given claimants an equity interest in LBI, the Equity Awards Claims would be subject to reclassification as equity interests. Section 501(a) of the Bankruptcy Code provides that a creditor may file a proof of claim and that an equity security holder may file a proof of interest. 11 U.S.C. § 501(a). Contracts concerning a variety of stock-based transactions, including the right to acquire stock, qualify as equity securities under the Bankruptcy Code. *See, e.g., In re Enron Corp.*, 341 B.R. 141, 162-63 (Bankr. S.D.N.Y. 2006) (holding that a "phantom" stock purchase program where delivery of shares was deferred for tax purposes qualified as a security for the purpose of distribution under the Bankruptcy Code). The Equity Awards gave claimants the right to acquire stock in LBHI after the satisfaction of certain conditions and thus must be deemed "equity securities" under the Bankruptcy Code.

In addition, even if the holders of the Equity Awards Claims had articulated any legal or factual justification for asserting a claim against LBI based on the Equity Awards, these claims would be subordinated pursuant to section 510 of the Bankruptcy Code on several grounds. First, certain of the Equity Awards are governed by agreements which provided that, in the event of a bankruptcy of LBHI, all claims arising from, in connection with, or in any way relating to any failure to deliver shares of common stock shall have the same priority as, and no greater priority than, common stock interests in LBHI. Subordination agreements such as these are enforceable in bankruptcy. 11 U.S.C. § 510(a); *see, e.g., In re Leasing Consultants, Inc.*, 2 B.R. 165, 168 (Bankr. E.D.N.Y. 1980), citing *In re Credit Indus. Corp.*, 366 F.2d 402, 407 (2d Cir. 1966). Second, any claim arising from the Equity Awards would be subject to subordination under section 510(b) of the Bankruptcy Code, which provides that for purposes of distribution, a claim for damages arising from the purchase or sale of a security shall have the same priority as the security. 11 U.S.C. § 510(b). The grant of securities as part of a compensation package qualifies as "a purchase or sale" of a security for the purposes of section 510(b). *See, e.g., Spirnak v. Motors Liquidation Co. GUC Trust (In re Motor Liquidation Co.)*, No. 11 Civ. 7893(DLC), 2012 WL 398640, at *4 (S.D.N.Y. Feb. 7, 2012); *In re WorldCom, Inc.*, No. 02-13533(AJG), 2006 WL 3782712, at *5-6 (S.D.N.Y. Dec. 21, 2006). "Physical possession of the security is not required for a claim based upon that security to be subordinated." *Enron*, 341 B.R. at 163 (citing *American Broad. Sys. v. Nugent (In re Betacom of Phoenix, Inc.)*, 240 F.3d 823, 829-30 (9th Cir. 2001)). Therefore, as this Court held in *Enron*,

(Footnote continued on next page)

hold valid claims against the LBI estate will recover. Thus, the Trustee requests that the Court enter an order disallowing and expunging in their entirety the Equity Awards Claims.

C. The Accrued Equity Claims Should Be Reclassified As Equity Interests And Subordinated Under Section 510(b) Of The Bankruptcy Code.

46. Based on analysis by the Trustee's counsel of the Accrued Equity Claims and other relevant documents and materials, the Trustee has identified the Accrued Equity Claims as claims that should be subordinated pursuant to section 510(b) of the Bankruptcy Code because the Accrued Equity Claims are based on the right to equity in LBHI.

47. Section 510(b), as made applicable to this proceeding pursuant to sections 78fff(b) and 78fff-1(a) of SIPA, provides that, for the purpose of distribution, a claim for damages arising from the purchase or sale of a security of an affiliate of the debtor must have the same priority as the underlying security. 11 U.S.C. § 510(b). A claim premised on the failure to deliver securities under a contract constitutes a claim for damages that must be subordinated under section 510(b). *See In re Med Diversified Inc.*, 461 F.3d 251, 258-59 (2d Cir. 2006); *see also In re Telegroup, Inc.*, 281 F.3d 133 (3d Cir. 2002) (subordinating claims pursuant to section 510(b) where the debtor breached a contractual obligation to use its best efforts to register the claimants' securities); *American Broad. Sys. v. Nugent (In re Betacom of Phoenix, Inc.)*, 240 F.3d 823 (9th Cir. 2001) (subordinating claims under section 510(b) where the debtor failed to deliver securities pursuant to a merger agreement). Therefore, as the Accrued Equity Claims are based on the failure to deliver accrued Equity Awards to the claimants, these claims must be subordinated to claims in the general creditor estate pursuant to section 510(b).

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claims for the payment of damages in connection with equity-related awards granted to employees as a component of compensation must be subordinated under section 510(b) of the Bankruptcy Code. *Id.*

48. As this Court recently held in this proceeding, the plain language of section 510(b) unambiguously mandates subordination of claims arising from the purchase or sale of a security of an affiliate of the debtor. (Mem. Op. Authorizing and Directing the Subordination of Claims of Claren Road Credit Master Fund Ltd. and Certain Underwriters at 8-14, *In re Lehman Brothers Inc.*, No. 08-01420 (JMP) SIPA (Jan. 27, 2014) (Docket No. 8127) (subordinating claims based on LBI's breach of an agreement to purchase LBHI securities from a claimant), *appeals docketed*, *Claren Road v. Giddens*, 14-CV-01742 (SAS) (S.D.N.Y. March 13, 2014); *ANZ Securities, Inc., v. Giddens*, 14-CV-01987 (SAS) (S.D.N.Y. March 21, 2014); *UBS Fin. Servs. Inc. v. Giddens*, 14-CV-02305 (SAS) (S.D.N.Y. April 2, 2014).)

49. Courts have generally applied section 510(b) liberally, to a wide variety of claims. Indeed, the Second Circuit has instructed that section 510(b) should be "interpret[ed] broadly." *Med Diversified*, 461 F.3d at 259. In agreeing to accept compensation in the form of Equity Awards, the Accrued Equity claimants "took on the risk and return expectations of a shareholder, rather than a creditor." *Med Diversified*, 461 F.3d at 256. They therefore should not also be allowed to "share with creditors [now that] the enterprise [has been] forced to . . . liquidate." *Id.* at 256 (internal quotations omitted). Therefore, the Trustee requests that the Court enter an order reclassifying and subordinating to general creditor claims under section 510(b) in their entirety the Accrued Equity Claims.¹¹

11. The Trustee takes no position as to the validity, value, or level of priority of any subordinated and reclassified Accrued Equity Claims at this time and reserves the right to raise arguments as to these issues should the need arise.

D. The Bonus Equity Claim Should Be Reclassified As Equity Interests And Subordinated Under Section 510(b) Of The Bankruptcy Code.

50. Based on analysis by the Trustee's counsel of the Bonus Equity Claim, the Books and Records, and other relevant documents and materials, the Trustee has identified the Bonus Equity Claim as a claim that should be subordinated pursuant to section 510(b) of the Bankruptcy Code because the Bonus Equity Claim is based on the right to equity in LBHI.

51. As discussed above in Section V.C, claims based on the alleged right to receive Equity Awards must be subordinated and reclassified as equity under section 510(b) of the Bankruptcy Code, as made applicable to this proceeding pursuant to sections 78fff(b) and 78fff-1(a) of SIPA. In agreeing to accept compensation in the form of Equity Awards, the Bonus Equity claimant "took on the risk and return expectations of a shareholder, rather than a creditor." *Med Diversified*, 461 F.3d at 256. He therefore should not also be allowed to "share with creditors [now that] the enterprise [has been] forced to . . . liquidate." *Id.* at 256 (internal quotations omitted). Therefore, the Trustee requests that the Court enter an order reclassifying and subordinating to general creditor claims under section 510(b) the Bonus Equity Claim.¹²

RESERVATION OF RIGHTS

52. The Trustee reserves all rights to object on any other basis to any Employee Claim or any portion of any Employee Claim for which the Court does not grant the relief requested herein. The Trustee further reserves all rights to object to the validity and/or value of any Employee Claim which is reclassified and subordinated.

12. The Trustee takes no position as to the validity, value, or level of priority of the subordinated and reclassified Bonus Equity Claim at this time and reserves the right to raise arguments as to these issues should the need arise.

NOTICE

53. Notice of this Two Hundred Fifty-Sixth Omnibus Objection to General Creditor Claims has been provided to (i) each claimant listed on Exhibit A via First-Class Mail; and (ii) the list of parties requesting notice of pleadings in accordance with the Court's Amended Order Pursuant to Section 105(a) of the Bankruptcy Code and Bankruptcy Rules 1015(c) and 9007 Implementing Certain Notice and Case Management Procedures and Related Relief entered by the Court on July 13, 2010 (ECF No. 3466), and will be immediately available for inspection upon filing with the Court at the Trustee's website, www.lehmantrustee.com. The Trustee submits that no other or further notice need be provided.

NO PRIOR RELIEF REQUESTED

54. No previous request for the relief requested herein has been made by the Trustee to this or any other Court, except that the Trustee previously filed an objection to the claim numbered 34 filed by Patrick Cunningham on the grounds that documentation portion of this claim should be reclassified as equity interests. (*See* ECF No. 9478.) That portion of claim number 34 is not affected by this objection. However, by this Objection, the Trustee now objects to the claim numbered 34 for the additional reasons stated on Exhibit A.

CONCLUSION

For the reasons stated herein, the Trustee respectfully requests entry of an order granting the relief requested herein and such other and further relief as is just.

Dated: New York, New York
August 1, 2014

HUGHES HUBBARD & REED LLP

/s/ James B. Kobak, Jr.
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Attorneys for James W. Giddens,
Trustee for the SIPA Liquidation of
Lehman Brothers Inc.

EXHIBIT A

IN RE LEHMAN BROTHERS INC., CASE NO: 08-01420 (SCC) SIPA
TWO HUNDRED FIFTY-SIXTH OMNIBUS OBJECTION: EXHIBIT A – EMPLOYEE CLAIMS

Claim Type	Trustee's Proposed Reason for Disallowance, Subordination, and/or Reclassification
Commissions Claim	The claim must be reduced because it does not accord with calculations based on LBI's books and records.
Severance Claim	The claim must be reduced to the accurate amount due under the claimant's severance agreement, as shown in LBI's books and records.
Hypo-Tax Claim	The claim must be reduced to the accurate amount due on account of estimated hypothetical tax withholdings for former LBI employees working abroad, as shown in LBI's books and records.
Deferred Compensation Claim	The claimed amount must be reduced to the correct amount due under the claimant's deferred compensation agreement.
Capped Claim	The claims must be capped at the amount of one year's compensation under the applicable employment agreement pursuant to Bankruptcy Code section 502(b)(7).
Misclassified Claim	The claim must be reclassified, in whole or in part, to a general unsecured claim in accordance with Bankruptcy Code sections 506 or 507.
Insufficient Documentation Claim	Claim lacks sufficient documentation.
Equity Awards Claim	No legal or factual justification for asserting a claim against LBI. The claimed Equity Awards constitute equity interests in LBHI, not LBI, the debtor in this separate and distinct SIPA proceeding.
Accrued Equity Claim	The Accrued Equity Claim is based on the alleged pre-petition right to receive accrued equity in LBHI, an affiliate of LBI, and therefore must be reclassified as equity interests and subordinated pursuant to section 510(b) of the Bankruptcy Code.
Bonus Equity Claim	The Bonus Equity Claims are based on the alleged pre-petition right to receive equity in LBHI, an affiliate of LBI, and therefore must be reclassified as equity interests and subordinated pursuant to section 510(b) of the Bankruptcy Code.

IN RE LEHMAN BROTHERS INC., CASE No: 08-01420 (SCC) SIPA
TWO HUNDRED FIFTY-SIXTH OMNIBUS OBJECTION: EXHIBIT A- EMPLOYEE CLAIMS

	NAME / ADDRESS OF CLAIMANT	CLAIM NUMBER	DATE FILED	ASSERTED AMOUNT**	CLAIM AS MODIFIED	COMM. CLAIM	MISCLASS. CLAIM	SEV. CLAIM	EQUITY AWARDS CLAIM	ACCRUED EQUITY CLAIM	DEF. COMP CLAIM	BONUS EQUITY CLAIM	CAPPED CLAIM	HYPOTAX CLAIM	INSUFF. DOC CLAIM
1	ACKERS, CLIFFORD BRYANT 40 PEAR TREE POINT ROAD DARIEN, CT 06820	7000214	12/14/2008	- (A) - (S) \$459,000.00 (P) - (U) \$459,000.00 (T)	- (A) - (S) - (P) \$459,000.00 (U) \$459,000.00 (T)		X								
2	BHUTANI, SARABJIT SINGH 3 TREGUNTER PATH, APT 5B BRANKSOME GRANDE MIDLEVELS HONG KONG CHINA	3268	2/2/2009	- (A) - (S) \$635,685.00 (P) - (U) \$635,685.00 (T)	- (A) - (S) \$10,950.00 (P) \$507,485.16 (U) \$518,435.16 (T) ¹		X	X						X	
3	BREWSTER, MICHAEL J. 269 WESTLAKE BLVD MAHOPAC, NY 10541	7001092	1/30/2009	- (A) - (S) \$190,125.00 (P) - (U) \$190,125.00 (T)	- (A) - (S) \$10,950.00 (P) \$71,937.29 (U) \$82,887.29 (T)	X	X								
4	BRITO, ROBERT M. 828 3RD STREET, PH3 MIAMI BEACH, FL 33139	4516	5/12/2009	- (A) - (S) \$15,183.30 (P) - (U) \$15,183.30 (T)	- (A) - (S) \$10,950.00 (P) \$4,233.30 (U) \$15,183.30 (T)		X								

1. The amount to be allowed for claim number 3268, listed in the column entitled “Claim as Modified,” reflects both amounts associated with items discussed in the Two Hundred Fifty-Fifth Omnibus Objection to General Creditor Claims and amounts associated with an additional Allowable Portion for expenses.

<p>– SECURED (P) – PRIORITY (U) – UNSECURED (T) – TOTAL CLAIMED</p>

* Claim includes unspecified amounts (i.e., amounts not specified by the claimant, amounts listed in a foreign currency, unliquidated amounts and/or amounts listed as “unknown”, “\$0.00*”, “unascertainable”, “undetermined”, or where no dollar amounts were entered in the spaces provided on the proof of claim form), or is a customer claim reclassified to a general creditor claim, which, consistent with the general creditor claims register, is listed as unspecified even where the claimant listed a specific amount on the SIPC customer claim form.

** The values listed are the asserted values as they appear on the LBI general claims register as maintained by the Trustee’s claims agent, and do not necessarily reflect the caps set by the Secured and Priority Claims Reserve Order and Unsecured Claims Reserve Order.

	NAME / ADDRESS OF CLAIMANT	CLAIM NUMBER	DATE FILED	ASSERTED AMOUNT**	CLAIM AS MODIFIED	COMM. CLAIM	MISCLASS. CLAIM	SEV. CLAIM	EQUITY AWARDS CLAIM	ACCRUED EQUITY CLAIM	DEF. COMP CLAIM	BONUS EQUITY CLAIM	CAPPED CLAIM	HYPOTAX CLAIM	INSUFF. DOC CLAIM
5	CAZZOLI, RICCARDO 24 WEST 96TH STREET APARTMENT 3F NEW YORK, NY 10025	7001109	1/14/2009	- (A) - (S) \$191,798.00 (P) \$136,650.15 (U) \$328,448.15 (T)	- (A) - (S) - (P) \$180,000.00 (U) \$180,000.00 (T)		X		X					X	
6	CUNNINGHAM, PATRICK 4926 PERSHING AVE DOWNERS GROVE, IL 60515	34	12/8/2008	- (A) - (S) \$16,322.02 (P) - (U) \$16,322.02 (T)	- (A) - (S) \$10,950.00 (P) \$5,372.02 (U) \$16,322.02 (T) ²		X								
7	FLIEDNER, COREY 16 CREST HILL CT HUNTINGTON STATION, NY 11790	5194	5/29/2009	- (A) - (S) \$4,153.85 (P) \$55,282.87 (U) \$59,436.72 (T)	- (A) - (S) \$4,153.85 (P) \$39,807.70 (U) \$43,961.55 (T)			X							
8	GLISKER, GEORGE 139 EUSTON ROAD GARDEN CITY, NY 11530	7001532	5/14/2009	- (A) \$69,541.76 (S) - (P) \$69,541.76 (U) \$69,541.76 (T)	- (A) - (S) - (P) \$69,541.76 (U) \$69,541.76 (T)		X								
9	KANE, JEANNE 24 SCHERMERHORN STREET BROOKLYN, NY 11201	4509	4/17/2009	- (A) - (S) \$3,696.00 (P) \$151,200.00 (U) \$154,896.00 (T)	- (A) - (S) \$3,696.00 (P) \$130,919.43 (U) \$134,615.43 (T)			X							

2. The portion of claim number 34 which asserts a claim for Accrued Equity is currently subject to the Trustee's One Hundred Fifty-First Omnibus Objection to General Creditor Claims (ECF 9478). This portion of the claim is unaffected by this Two Hundred Fifty-Fifth Omnibus Objection to General Creditor Claims.

(A) – ADMINISTRATIVE
(S) – SECURED
(P) – PRIORITY
(U) – UNSECURED
(T) – TOTAL CLAIMED

* Claim includes unspecified amounts (i.e., amounts not specified by the claimant, amounts listed in a foreign currency, unliquidated amounts and/or amounts listed as “unknown”, “\$0.00*”, “unascertainable”, “undetermined”, or where no dollar amounts were entered in the spaces provided on the proof of claim form), or is a customer claim reclassified to a general creditor claim, which, consistent with the general creditor claims register, is listed as unspecified even where the claimant listed a specific amount on the SIPC customer claim form.

** The values listed are the asserted values as they appear on the LBI general claims register as maintained by the Trustee's claims agent, and do not necessarily reflect the caps set by the Secured and Priority Claims Reserve Order and Unsecured Claims Reserve Order.

	NAME / ADDRESS OF CLAIMANT	CLAIM NUMBER	DATE FILED	ASSERTED AMOUNT**	CLAIM AS MODIFIED	COMM. CLAIM	MISCLASS. CLAIM	SEV. CLAIM	EQUITY AWARDS CLAIM	ACCRUED EQUITY CLAIM	DEF. COMP CLAIM	BONUS EQUITY CLAIM	CAPPED CLAIM	HYPOTAX CLAIM	INSUFF. DOC CLAIM
10	KENT, ELIZABETH AMANDA 111 EAST 85TH STREET APT. 23E NEW YORK, NY 10028	1851	1/28/2009	- (A) - (S) \$10,950.00 (P) \$12,848.10 (U) \$23,798.10 (T)	- (A) - (S) \$10,950.00 (P) \$9,146.18 (U) \$20,096.18 (T)			X	X						
11	LAZARES, NICHOLAS W. 255 ADAMS ST. MILTON, MA 02186	7002114	5/26/2009	- (A) - (S) - (P) \$8,625,000.00 (U) \$8,625,000.00 (T)	- (A) - (S) - (P) \$1,637,500.00 (U) \$1,637,500.00 (T)				X				X		
12	LUCAS, VINCENT GEOFFREY UNIT #1023 GREENWICH CLUB RESIDENCES NEW YORK, NY 10006	7001032	1/30/2009	- (A) - (S) \$167,123.00 (P) - (U) \$167,123.00 (T)	- (A) - (S) - (P) \$167,123.00 (U) \$167,123.00 (T)		X								
13	OOKA, TAMIKO LUMIERE DE MITA #203 2-1-41 MITA MINATO-KU TOKYO 108-0073 JAPAN	8001776	1/28/2009	- (A) - (S) - (P) UNSPECIFIED* (U) UNSPECIFIED* (T)	- (A) - (S) - (P) \$108,333.36 (U) \$108,333.36 (T)			X							X
14	OSGOOD, MARK 1218 COLONY PLAZA NEWPORT BEACH, CA 92660	8000018	12/2/2008	- (A) - (S) - (P) UNSPECIFIED* (U) UNSPECIFIED* (T)	- (A) - (S) - (P) \$800,000.00 (U) \$800,000.00 (T)							X			
15	PRESTON, GERAINT 75 WALL STREET, #22M NEW YORK, NY 10005	8001960	1/28/2009	- (A) - (S) - (P) UNSPECIFIED* (U) UNSPECIFIED* (T)	- (A) - (S) - (P) \$101,928.00 (U) \$101,928.00 (T)				X					X	

(A) – ADMINISTRATIVE
(S) – SECURED
(P) – PRIORITY
(U) – UNSECURED
(T) – TOTAL CLAIMED

* Claim includes unspecified amounts (i.e., amounts not specified by the claimant, amounts listed in a foreign currency, unliquidated amounts and/or amounts listed as “unknown”, “\$0.00*”, “unascertainable”, “undetermined”, or where no dollar amounts were entered in the spaces provided on the proof of claim form), or is a customer claim reclassified to a general creditor claim, which, consistent with the general creditor claims register, is listed as unspecified even where the claimant listed a specific amount on the SIPC customer claim form.

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	NAME / ADDRESS OF CLAIMANT	CLAIM NUMBER	DATE FILED	ASSERTED AMOUNT**	CLAIM AS MODIFIED	COMM. CLAIM	MISCLASS. CLAIM	SEV. CLAIM	EQUITY AWARDS CLAIM	ACCRUED EQUITY CLAIM	DEF. COMP CLAIM	BONUS EQUITY CLAIM	CAPPED CLAIM	HYPOTAX CLAIM	INSUFF. DOC CLAIM
16	SIECZKOWSKI, WALTER J. 30 CLUB DRIVE MASSAPEQUA, NY 11758	4698	5/22/2009	- (A) \$916,878.00 (S) - (P) \$916,878.00 (U) \$916,878.00 (T)	- (A) - (S) - (P) \$672,507.62 (U) \$672,507.62 (T)		X				X				
17	SULLIVAN, MARK L. 21 OVERHILL AVENUE RYE, NY 10580	7001064	1/30/2009	- (A) - (S) \$102,365.00 (P) - (U) \$102,365.00 (T)	- (A) - (S) \$10,950.00 (P) \$58,853.31 (U) \$69,803.31 (T)	X	X								
18	THAI, THANH HUNG BLOCK E, 28/F, THE MANHATTAN, 33 TAI TAM ROAD TAI TAM HONG KONG HONG KONG	7002047	5/27/2009	- (A) - (S) \$10,950.00 (P) \$526,003.86 (U) \$536,953.86 (T)	- (A) - (S) \$10,950.00 (P) \$382,166.59 (U) \$393,116.59 (T) ³									X	X
19	THOMAS ANDREW OLLQUIST PRIVATE EQUITY ACCOUNT 190 BEDELL AVENUE WEST HEMPSTEAD, NY 11550	7002344	5/31/2009	- (A) - (S) \$200,000.00 (P) - (U) \$200,000.00 (T)	- (A) - (S) \$10,950.00 (P) \$49,834.18 (U) \$60,784.18 (T) ⁴		X	X	X	X					

- The amount to be allowed for claim number 7002047, listed in the column entitled "Claim as Modified," reflects both amounts associated with items discussed in the Two Hundred Fifty-Fifth Omnibus Objection to General Creditor Claims and amounts associated with an additional Allowable Portion for unpaid severance.
- The amount to be allowed for claim number 7002344, listed in the column entitled "Claim as Modified," reflects both amounts associated with items discussed in the Two Hundred Fifty-Fifth Omnibus Objection to General Creditor Claims and amounts associated with an additional Allowable Portion for unpaid compensation.

(A) – ADMINISTRATIVE
(S) – SECURED
(P) – PRIORITY
(U) – UNSECURED
(T) – TOTAL CLAIMED

* Claim includes unspecified amounts (i.e., amounts not specified by the claimant, amounts listed in a foreign currency, unliquidated amounts and/or amounts listed as "unknown", "\$0.00*", "unascertainable", "undetermined", or where no dollar amounts were entered in the spaces provided on the proof of claim form), or is a customer claim reclassified to a general creditor claim, which, consistent with the general creditor claims register, is listed as unspecified even where the claimant listed a specific amount on the SIPC customer claim form.

** The values listed are the asserted values as they appear on the LBI general claims register as maintained by the Trustee's claims agent, and do not necessarily reflect the caps set by the Secured and Priority Claims Reserve Order and Unsecured Claims Reserve Order.

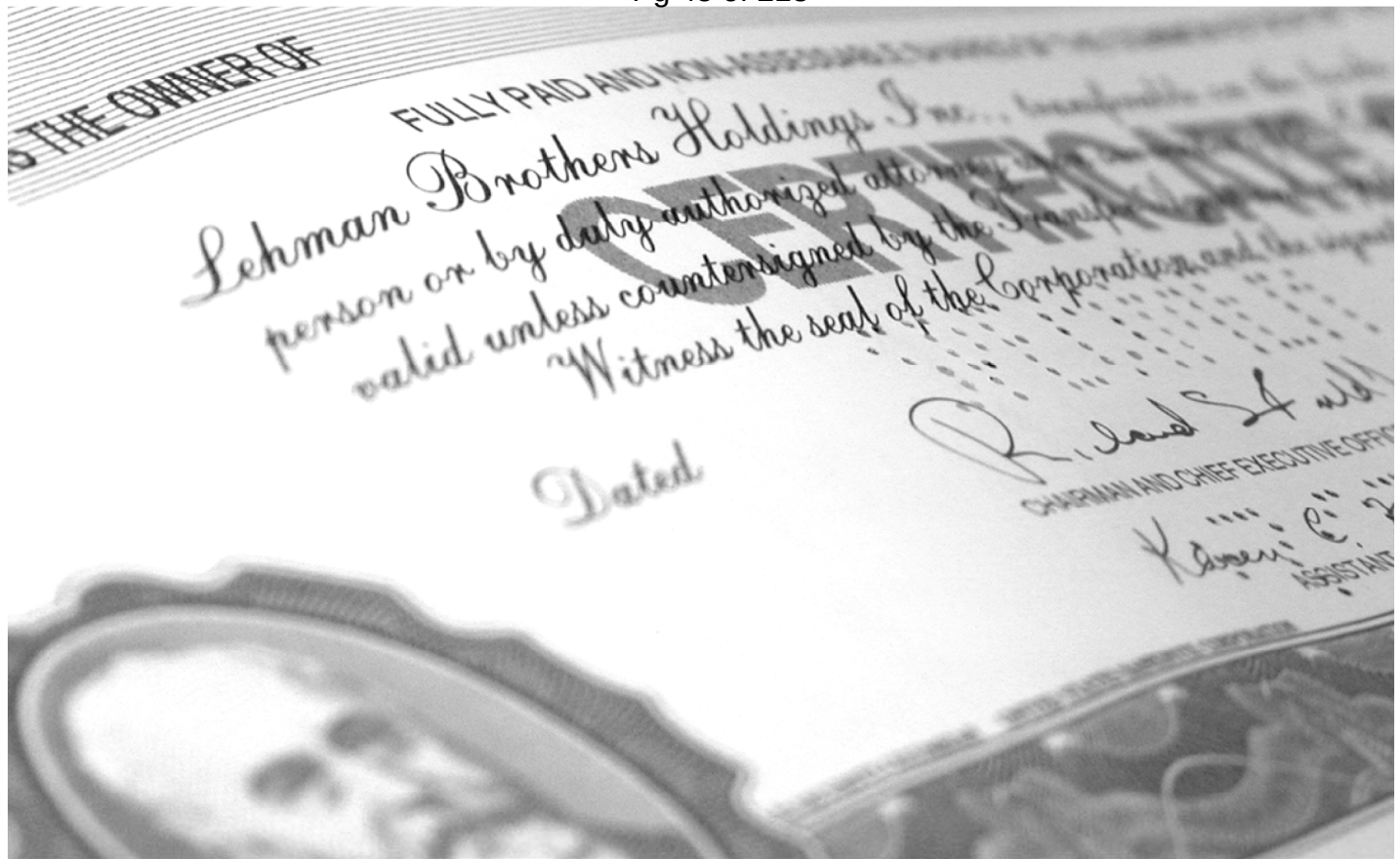
	NAME / ADDRESS OF CLAIMANT	CLAIM NUMBER	DATE FILED	ASSERTED AMOUNT**	CLAIM AS MODIFIED	COMM. CLAIM	MISCLASS. CLAIM	SEV. CLAIM	EQUITY AWARDS CLAIM	ACCRUED EQUITY CLAIM	DEF. COMP CLAIM	BONUS EQUITY CLAIM	CAPPED CLAIM	HYPO-TAX CLAIM	INSUFF. DOC CLAIM
20	WANG, JANE (JIANGLING) 8212 LAUREL HEIGHTS LOOP LORTON, VA 22079	6075	7/27/2009	- (A) \$1,449.60 (S) \$1,449.60 (P) - (U) \$1,449.60 (T)	- (A) - (S) \$1,449.60 (P) - (U) \$1,449.60 (T)		X								
21	WAYNE, RICHARD N. 25 TRAILSIDE ROAD WESTON, MA 02493	7002113	5/26/2009	- (A) - (S) - (P) \$8,625,000.00 (U) \$8,625,000.00 (T)	- (A) - (S) - (P) \$1,637,500.00 (U) \$1,637,500.00 (T)				X				X		

(A) – ADMINISTRATIVE
(S) – SECURED
(P) – PRIORITY
(U) – UNSECURED
(T) – TOTAL CLAIMED

* Claim includes unspecified amounts (i.e., amounts not specified by the claimant, amounts listed in a foreign currency, unliquidated amounts and/or amounts listed as “unknown”, “\$0.00*”, “unascertainable”, “undetermined”, or where no dollar amounts were entered in the spaces provided on the proof of claim form), or is a customer claim reclassified to a general creditor claim, which, consistent with the general creditor claims register, is listed as unspecified even where the claimant listed a specific amount on the SIPC customer claim form.

** The values listed are the asserted values as they appear on the LBI general claims register as maintained by the Trustee’s claims agent, and do not necessarily reflect the caps set by the Secured and Priority Claims Reserve Order and Unsecured Claims Reserve Order.

EXHIBIT B



2008 EQUITY AWARD PROGRAM

L I F E @ L E H M A N

YOUR BENEFITS AND LIFE BALANCE

Questions and Answers for Bonus-Eligible Employees
and Production-Based Employees

THIS DOCUMENT IS PROVIDED FOR INFORMATION PURPOSES ONLY. These Questions and Answers are intended to provide a general overview of the 2008 Equity Award Program. All terms and conditions of the 2008 Equity Award Program are subject to the applicable controlling plan documents, including but not limited to the Restricted Stock Unit Award Agreement, the 2005 Stock Incentive Plan, and the 2005 Stock Incentive Plan Prospectus. In the event of any conflict between the plan documents and the information in this document, the plan documents will govern.

LEHMAN BROTHERS

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OVERVIEW OF 2008 CHANGES

Q1 HOW WILL THE 2008 EQUITY AWARD DIFFER FROM LAST YEAR'S AWARD?

A1 The Firm reviews the terms of the Equity Award Program annually and based on input from many employees has decided on several changes for 2008. These changes are designed to achieve a number of objectives, including:

- **Simplifying the program:** the Equity Award Program has been the only one among our competitors with multiple vesting schedules and deferral levels based on corporate title;
- **Aligning the program more closely with competitor programs:** the Equity Award Program in past years has provided an equity award discount, but the awards have been subject to the longest vesting and sales restrictions among our competitors.
 - Among our major competitors, Goldman Sachs, JP Morgan, Merrill Lynch, and Morgan Stanley provide no discount on employee equity awards.
- **Preserving our ownership culture:** as in the past, the overall objective of the Firm's Equity Award Program is to ensure multi-year alignment with shareholders through significant ownership stakes for employees.

As in prior years, 100% of the 2008 equity award will be in the form of Restricted Stock Units ("RSUs"). The 3 primary changes to the 2008 program are:

1. **Equity Discount:** Beginning with the 2008 equity award, employees will **no longer be granted RSUs at a discount** from their fair market value at the time of grant. However, RSUs will be subject to a much shorter holding period. See "Holding Period" below.
2. **Vesting Schedule:** Under the 2008 Equity Award Program, the vesting schedule for all employees will be the same, irrespective of corporate title: **33% per year over 3 years** (1/3 vesting on November 30, 2009, 1/3 vesting on November 30, 2010, and 1/3 vesting on November 30, 2011, respectively).
3. **Holding Period:** In 2008, the holding period will be reduced from 5 years to **3 years**. This means that vested 2008 RSUs will convert to shares of Lehman Brothers common stock in 2011, rather than in 2013.

Q2 WHEN WILL I BE GRANTED MY 2008 EQUITY AWARD?

- A2 Eligible employees' 2008 equity award will comprise two separate grants on **two dates**: a) a grant on July 1, 2008 (the "July RSUs") and b) a grant at a date to be determined by Compensation and Benefits Committee of the Board of Directors during the fourth quarter (the "Year-end Award"). You can consider the July award, which is generally 20% of the 2007 award, as an advance on any full-year 2008 award that you may receive. The July RSUs and any Year-end Award will vest and deliver on the same schedule (see below).

This special off-cycle grant underscores our confidence in Lehman Brothers' future and provides each of us with an opportunity to take advantage of the upside potential in our stock price. Further information on the July award is provided in the "July Award" section below.

Q3 HOW WILL 2008 EQUITY AWARD LEVELS COMPARE TO LAST YEAR?

- A3 For 2008, we have simplified the Equity Award Schedule by consolidating the 3 separate schedules (for MDs, SVPs, and employees through the VP level) into one schedule applicable to bonus-eligible employees¹ regardless of corporate title and based on total compensation levels. In general, for bonus-eligible employees the percentage of 2008 total compensation delivered in equity awards will **increase** from 2007, with the maximum percentage increasing from 50% to 65%; for employees earning \$100,000 or less in total compensation, however, the percentages are about the same as in 2007.

See Exhibit A for the 2007 Equity Award Schedule and Exhibit B for the 2008 Equity Award Schedule for bonus-eligible employees.

Note that for production-based² and certain other employees, the schedule will be as previously communicated. See Exhibit C for the 2008 Equity Award Schedule for production-based employees.

¹ For purposes of this document, all references to "bonus-eligible" employees refer to employees who are not considered "production-based" (see footnote 2 below) and who would be eligible to receive a year-end 2008 discretionary bonus, assuming continued employment in accordance with the bonus policy. Note that for individuals with written compensation guarantees for 2008, the Equity Award Schedule applicable for the determination of your full-year equity award is the schedule communicated as part of your guarantee.

² For purposes of the Equity Award Program, "production-based" employees are those employees, like Investment Representatives, who throughout the performance year receive production-based compensation a portion of which is cash (e.g., commissions) and a portion of which represents an accrual toward a year-end equity award. "Production-based" employees typically do not receive any year-end bonus. Employees are classified as "production-based" or "bonus-eligible" in the Firm's discretion. If you have questions about your classification, please contact the Compensation Department or your Human Resources representative.

July Award

Q4 WHO IS ELIGIBLE FOR A JULY EQUITY AWARD?

- A4 Employees whose employment started on or before July 1, 2008 are generally eligible for a July equity award for 2008, including employees on an approved leave of absence. Certain employees will not receive a July award, including, among others: employees currently in the Firm's formal Analyst Programs (including recently "promoted" Analysts), certain part-time, temporary or seasonal employees, employees on long-term disability, employees who have given notice or have been notified of their termination, certain employees in proprietary trading roles, employees notified that they will not be receiving a July award, and individuals employed by certain subsidiaries. In addition, in the case of production-based employees, anyone with a 2008 equity award accrual from January 2008 through June 2008 is eligible for a July award.

Q5 HOW WAS THE VALUE OF MY JULY EQUITY AWARD CALCULATED?

A5 **Bonus-eligible Employees**

For most employees (hired on or prior to December 1, 2006), the value of the July RSUs was calculated as 20% of the principal portion³ of the 2007 equity award. In other words, the July award is based on 2007 compensation applied to the 2007 Equity Award Schedule in Exhibit A, multiplied by 20%.

If you joined the Firm during fiscal year 2007, the July RSUs were calculated based on your 2007 annual base salary, additional eligible compensation for 2007, and any 2007 paid bonus.

If you joined the Firm during fiscal year 2008, the July RSUs were calculated based on your 2008 annual base salary, additional eligible compensation for 2008, and any 2008 written compensation guarantee.

The use of 2007 compensation for the purposes of calculating the July RSUs does not indicate any right or eligibility for compensation in 2008 (or 2008 compensation at any particular level or range) or to any additional equity award for the 2008 performance year.

Production-based Employees

Your July RSUs have been calculated based upon your **annualized** production payout and other compensation, after all adjustments, for production months December 2007 through May 2008 (relating to pay periods from January through June 2008). See Exhibit D for examples of how the July equity award was determined.

³ The principal portion of the 2007 equity award was the amount awarded as part of your 2007 total compensation (before the discount).

Q6 HOW MANY JULY RSUs HAVE I BEEN GRANTED?

- A6 To determine the number of July RSUs you have been granted, simply take the value calculated using the methodology described in Question 5 above and divide it by the grant price of \$20.96, the closing stock price of Lehman Brothers common stock on July 1, 2008.

Example (for a VP hired prior to December 1, 2006):

2007 Total Compensation	Principal Portion of 2007 Award	July Award (@20%)	July Grant Price	Number of July RSUs
\$200,000	\$9,200	\$1,840	\$20.96	87.79

Note that if the calculation results in fewer than three (3) July RSUs, then no July RSUs will be granted.

Q7 WHY IS THE JULY EQUITY AWARD ONLY 20% OF LAST YEAR'S AWARD?

- A7 As in prior years, equity awards are intended as part of an employee's total compensation for the full performance year, and are therefore determined and granted at the time of any year-end bonuses. Because bonus compensation is fully discretionary (unless guaranteed in writing in accordance with Firm policy), the equity portion of total compensation for 2008 cannot be determined at this time. To maintain sufficient flexibility in the determination of pay for 2008—and to minimize the risk that employee cash bonuses are not adversely impacted—the Firm decided that the July award would be based on 20% of the prior year award for most employees. Please bear in mind that a July RSU award does not indicate any right to a discretionary bonus (or any particular amount of discretionary bonus) or to any additional equity award for the 2008 performance year.

Q8 HOW WERE THE GRANT DATE AND GRANT PRICE FOR THE JULY AWARD DETERMINED?

- A8 All equity grants to employees must be authorized and approved by the Compensation and Benefits Committee of the Board of Directors. The July 1 grant date was set by the Committee. The grant price for the July award is the closing market price of Lehman Brothers common stock on the New York Stock Exchange on that date, \$20.96, and is used to determine the number of July RSUs granted to you.

Q9 WHAT WILL HAPPEN TO MY JULY AWARD IF I LEAVE THE FIRM PRIOR TO NOVEMBER 30, 2008?

A9 Bonus-eligible Employees

If your employment with the Firm ceases, for any reason, prior to November 30, 2008, you will forfeit the July RSUs. If you leave the Firm on or after November 30, 2008, your entitlement to any July RSUs, the same as any Year-end Award, will depend on when you leave, the

circumstances under which you leave, and your conduct with respect to the Firm after you leave.

Production-based Employees

Your entitlement to the July award will depend on when you leave the Firm, why you leave, and your conduct with respect to the Firm after you leave.

Refer to the termination provisions on Exhibit E.

YEAR-END AWARD

Q10 WHO IS ELIGIBLE FOR A 2008 YEAR-END EQUITY AWARD?

A10 Employees (both bonus-eligible and production-based employees) whose employment started on or before the 2008 grant date, expected to be determined during the fourth quarter (the “Year-end Grant Date”), including employees on an approved leave of absence, are eligible to receive a year-end equity award for 2008, with the following exceptions: employees in the Firm’s formal Analyst Programs, certain temporary, part-time or seasonal employees, employees on long-term disability, employees who have given notice or have been notified of their termination; and individuals employed by certain subsidiaries. Any bonus-eligible employee whose employment terminates prior to the Year-end Grant Date, or who is otherwise not eligible for a year-end bonus, will not be eligible for a year-end equity award. In case of termination of employment of production-based employees or individuals with a written compensation guarantee, any year-end equity awards will be treated in accordance with the relevant plan provisions or terms of the written compensation guarantee.

Q11 HOW WILL MY 2008 YEAR-END EQUITY AWARD BE CALCULATED?

A11 Bonus-eligible Employees

Your Year-end equity award will be calculated based on your 2008 total compensation and the 2008 Equity Award Schedule for bonus-eligible employees shown on Exhibit B, reduced by the grant-date value of any July award. In no event, however, will your full-year award be less than your July Award. Total compensation includes salary earned in fiscal year 2008 plus any bonus and additional eligible compensation for your performance in 2008, whether such amounts are deferred or paid in 2008.

Note that for individuals with written compensation guarantees for 2008, the Equity Award Schedule applicable for the determination of your full-year equity award will be the one communicated as part of your guarantee. In all other respects, your 2008 Equity Award will be governed by the applicable 2008 Equity Award Program plan documents.

Production-based Employees

Your Year-end equity award will be calculated as above, except that it will be based on the 2008 Equity Award Schedule for production-based employees shown on Exhibit C and your actual production and other compensation, after all adjustments, for production months December 2007 through November 2008 (relating to pay periods from January through December 2008), reduced by the grant date value of any July award. In no event, however, will your full-year award be less than your July Award. Refer to Exhibit D for an illustration of how the 2008 Equity Award will be calculated for production-based employees.

Note that the 2009 Equity Award Schedule for production-based employees will be communicated no later than December 31, 2008.

2008 VESTING AND TERMINATION PROVISIONS

Q12 WHEN WILL MY 2008 RSUs VEST?

A12 The 2008 equity award (including any July RSUs) will vest in 1/3 increments on November 30, 2009, 2010 and 2011.

Q13 WHEN WILL MY 2008 RSUs CONVERT TO SHARES OF COMMON STOCK?

A13 Vested 2008 RSUs (including any July RSUs) will convert to shares of Lehman Brothers common stock on November 30, 2011.

Q14 WHAT WILL HAPPEN TO MY 2008 RSUs IF I RESIGN FROM THE FIRM?

A14 If you resign, you will forfeit all RSUs that are unvested at the time of your termination, unless you are eligible for Full Career treatment at the time of termination.

	% of Total Equity Award Retained		
	<i>If you resign from the Firm after November 30 of:</i>		
	<u>2009</u>	<u>2010</u>	<u>2011</u>
All Employees	33%	67%	100%

If you resign and your termination is deemed a Full Career termination, you will be entitled to 100% of your 2008 RSUs, and shares of Lehman Brothers common stock will be delivered to you on November 30, 2011, provided you satisfy all delivery conditions in your award agreements, do not engage in Detrimental Activity through November 30, 2011, and do not engage in Competitive Activity through the earlier of: (1) the end of the fiscal quarter 1 year following your termination and (2) November 30, 2011.

For bonus-eligible employees, note that “Full Career” treatment is not applicable for resignations occurring before November 30, 2008. See Exhibit E for termination provisions.

Q15 WHAT WILL HAPPEN TO MY 2008 RSUs IF MY EMPLOYMENT IS TERMINATED?

A15 As in prior years, if your employment with the Firm is terminated involuntarily without Cause, you will generally be eligible to retain your (otherwise forfeited) unvested 2008 RSUs, provided you sign a Firm-standard release agreement in accordance with Firm policy and provided you do not engage in Detrimental Activity. Your 2008 RSUs will convert to Lehman Brothers common stock and shares will be delivered on November 30, 2011. (If you do not sign a release agreement, you will be eligible to receive only the vested portion of your award.)

Note that the above does not apply to terminations occurring before November 30, 2008. Bonus-eligible employees whose employment ends for any reason before November 30, 2008 forfeit any July RSUs and are not entitled to any Year-end Award.

Note also that if you are terminated involuntarily with Cause, you will forfeit all outstanding RSUs. See Exhibit E for termination provisions.

GENERAL INFORMATION

Q16 WHERE CAN I FIND DETAILS REGARDING MY JULY AWARD AND MY OTHER EQUITY AWARDS?

A16 Details of your equity awards can be found on the Personal Award Summary of the Equity Award Program section of LehmanLive, which you can access by using keyword [equityaward](#). The number of July RSUs you were awarded, if any, will be available on LehmanLive **by July 15, 2008**.

Q17 DO ANY OF THE CHANGES TO THE EQUITY AWARD PROGRAM AFFECT AWARDS GRANTED IN PRIOR YEARS?

A17 No. The changes outlined here apply only to awards granted in 2008. These changes will not be retroactive to awards granted in prior years.

Q18 WHOM DO I CONTACT IF I HAVE FURTHER QUESTIONS REGARDING THE EQUITY AWARD PROGRAM?

A18 If you have any questions regarding the Equity Award Program, please contact the Compensation Department in New York at (212) 526-8346 or by e-mail at compensation@lehman.com.

EXHIBIT A: 2007 EQUITY AWARD SCHEDULE

Total Compensation Range	AMOUNT OF TOTAL COMPENSATION ("TC") IN EQUITY-BASED AWARDS		
	<i>Employees Through Vice President Level</i>	<i>Senior Vice Presidents</i>	<i>Managing Directors</i>
\$0 - \$74,999	1.15% of 2007 TC	2.3% of 2007 TC	2.3% of 2007 TC
\$75,000 - \$99,999	2.3% of 2007 TC	2.3% of 2007 TC	2.3% of 2007 TC
\$100,000 - \$199,999	\$2,300 plus 6.9% of 2007 TC over \$100,000	\$2,300 plus 6.9% of 2007 TC over \$100,000	\$2,300 plus 6.9% of 2007 TC over \$100,000
\$200,000 - \$299,999	\$9,200 plus 11.5% of 2007 TC over \$200,000	\$9,200 plus 11.5% of 2007 TC over \$200,000	\$9,200 plus 11.5% of 2007 TC over \$200,000
\$300,000 - \$499,999	\$20,700 plus 17.25% of 2007 TC over \$300,000	\$34,500 plus 18.687% of 2007 TC over \$300,000	\$34,500 plus 18.687% of 2007 TC over \$300,000
\$500,000 - \$749,999	\$55,200 plus 23% of 2007 TC over \$500,000	\$71,875 plus 23% of 2007 TC over \$500,000	\$71,875 plus 23% of 2007 TC over \$500,000
\$750,000 - \$999,999	\$112,700 plus 28.75% of 2007 TC over \$750,000	\$129,375 plus 40.25% of 2007 TC over \$750,000	\$129,375 plus 40.25% of 2007 TC over \$750,000
\$1,000,000 - \$1,499,999	\$192,600 plus 36% of 2007 TC over \$1.0 million	\$240,000 plus 42% of 2007 TC over \$1.0 million	\$240,000 plus 52.8% of 2007 TC over \$1.0 million
\$1,500,000 - \$1,999,999	\$372,600 plus 42% of 2007 TC over \$1.5 million	\$450,000 plus 54% of 2007 TC over \$1.5 million	\$504,000 plus 67.2% of 2007 TC over \$1.5 million
\$2,000,000 - \$2,499,999	\$582,600 plus 48% of 2007 TC over \$2.0 million	\$720,000 plus 66% of 2007 TC over \$2.0 million	\$840,000 plus 72% of 2007 TC over \$2.0 million
\$2,500,000 and up	\$822,600 plus 54% of 2007 TC over \$2.5 million up to a max of 36% of 2007 TC	42% of 2007 TC	\$1,200,000 plus 75% of 2007 TC over \$2.5 million to a max of 50% of 2007 TC

EXHIBIT B: 2008 EQUITY AWARD SCHEDULE FOR BONUS-ELIGIBLE EMPLOYEES

The portion of 2008 total compensation delivered in the form of an equity award for the full year will be calculated according to the schedule below. Any Year-end Award will be determined by subtracting any July RSUs from your full-year award, but in no event will your full-year award be less than your July RSUs.

2008 Total Compensation Range	AMOUNT OF TOTAL COMPENSATION ("TC") IN EQUITY-BASED AWARDS ⁴	MAXIMUM % OF TC IN EQUITY- BASED AWARDS
\$0 - \$74,999	1% of 2008 TC	1%
\$75,000 - \$99,999	2% of 2008 TC	2%
\$100,000 - \$299,999	\$2,000 plus 14% of 2008 TC above \$100,000	10%
\$300,000 - \$499,999	\$30,000 plus 35% of 2008 TC above \$300,000	20%
\$500,000 - \$749,999	\$100,000 plus 35% of 2008 TC above \$500,000	25%
\$750,000 - \$999,999	\$187,500 plus 65% of 2008 TC above \$750,000	35%
\$1,000,000 - \$1,499,999	\$350,000 plus 65% of 2008 TC above \$1,000,000	45%
\$1,500,000 - \$1,999,999	\$675,000 plus 85% of 2008 TC above \$1,500,000	55%
\$2,000,000 - \$2,499,999	\$1,100,000 plus 80% of 2008 TC above \$2,000,000	60%
\$2,500,000 and above	\$1,500,000 plus 90% of 2008 TC above \$2,500,000 up to a maximum of 65% of 2008 TC	65%

⁴ Subject to a 5-share minimum.

EXHIBIT C: 2008 EQUITY AWARD SCHEDULE FOR PRODUCTION-BASED EMPLOYEES

The portion of 2008 total compensation delivered in the form of an equity award for the full year will be calculated according to the schedule below, which is the same as the one previously communicated. Any Year-end Award will be determined by subtracting any July award from your full-year award, but in no event will your full-year award be less than your July RSUs.

2008 EQUITY AWARD SCHEDULE FOR PRODUCTION-BASED EMPLOYEES

2008 Total Compensation Range	AMOUNT OF TOTAL COMPENSATION ("TC") IN EQUITY-BASED AWARDS ⁵		
	<i>Employees Through Vice President Level</i>	<i>Senior Vice Presidents</i>	<i>Managing Directors</i>
\$0 - \$74,999	1.15% of 2008 TC	2.3% of 2008 TC	2.3% of 2008 TC
\$75,000 - \$99,999	2.3% of 2008 TC	2.3% of 2008 TC	2.3% of 2008 TC
\$100,000 - \$199,999	\$2,300 plus 6.9% of 2008 TC over \$100,000	\$2,300 plus 6.9% of 2008 TC over \$100,000	\$2,300 plus 6.9% of 2008 TC over \$100,000
\$200,000 - \$299,999	\$9,200 plus 11.5% of 2008 TC over \$200,000	\$9,200 plus 11.5% of 2008 TC over \$200,000	\$9,200 plus 11.5% of 2008 TC over \$200,000
\$300,000 - \$499,999	\$20,700 plus 17.25% of 2008 TC over \$300,000	\$34,500 plus 18.687% of 2008 TC over \$300,000	\$34,500 plus 18.687% of 2008 TC over \$300,000
\$500,000 - \$749,999	\$55,200 plus 23% of 2008 TC over \$500,000	\$71,875 plus 23% of 2008 TC over \$500,000	\$71,875 plus 23% of 2008 TC over \$500,000
\$750,000 - \$999,999	\$112,700 plus 28.75% of 2008 TC over \$750,000	\$129,375 plus 40.25% of 2008 TC over \$750,000	\$129,375 plus 40.25% of 2008 TC over \$750,000
\$1,000,000 - \$1,499,999	\$192,600 plus 36% of 2008 TC over \$1.0 million	\$240,000 plus 42% of 2008 TC over \$1.0 million	\$240,000 plus 52.8% of 2008 TC over \$1.0 million
\$1,500,000 - \$1,999,999	\$372,600 plus 42% of 2008 TC over \$1.5 million	\$450,000 plus 54% of 2008 TC over \$1.5 million	\$504,000 plus 67.2% of 2008 TC over \$1.5 million
\$2,000,000 - \$2,499,999	\$582,600 plus 48% of 2008 TC over \$2.0 million	\$720,000 plus 66% of 2008 TC over \$2.0 million	\$840,000 plus 72% of 2008 TC over \$2.0 million
\$2,500,000 and up	\$822,600 plus 54% of 2008 TC over \$2.5 million up to a max of 36% of 2008 TC	42% of 2008 TC	\$1,200,000 plus 75% of 2008 TC over \$2.5 million to a max of 50% of 2008 TC

⁵ Subject to a 5-share minimum.

EXHIBIT D: 2008 EQUITY AWARD CALCULATION FOR PRODUCTION-BASED EMPLOYEES

Your 2008 equity award will be calculated based on your 2008 production compensation and the 2008 Equity Award Schedule shown in Exhibit C, less the portion of compensation granted as July RSUs, if any. The examples below assume an individual with production compensation for the full year 2008.

Actual 2008 Production Compensation (through May production month):	\$125,000
Annualized 2008 Production Compensation (x 12 ÷ 6):	\$250,000
Annualized Equity Award (from Schedule for employees through VP level):	\$14,950
July Award (20% of Annualized Award):	\$2,990
Assumed 2008 Production Compensation:	\$250,000
Total 2008 Equity Award:	\$14,950
July Award:	\$2,990
2008 Year-End Equity Award:	<u>\$11,960</u>
Total 2008 Equity Award:	\$14,950

EXHIBIT E: TERMINATION PROVISIONS

	All Employees
Voluntary Termination <i>(but not Full Career)</i>	Participants will forfeit all unvested July RSUs and Year-end RSUs (together, “2008 RSUs”). Any vested 2008 RSUs will convert to shares of common stock and such shares will be delivered as soon as practicable after November 30, 2011 (the “Share Payment Date”) but not later than December 31, 2011, provided the participant does not engage in Detrimental Activity through that date and has not committed an act constituting Cause through the termination date.
Involuntary Termination <i>(but not Full Career)</i>	<p>Involuntary Termination without Cause: Participants will become entitled to 100% of their 2008 RSUs, including the unvested portion (provided the employee signs a Firm-standard release agreement). Shares will be delivered as soon as practicable after the Share Payment Date, but not later than December 31, 2011, provided the participant does not engage in Detrimental Activity through that date.</p> <p>Involuntary Termination with Cause: Participants will forfeit 100% of their 2008 RSUs.</p>
Full Career Termination	<p>Voluntary Termination: Participants will become entitled to 100% of their 2008 RSUs on the Share Payment Date, provided they do not engage in Competitive Activity through the end of the fiscal quarter following the one year anniversary of the termination date, and do not engage in Detrimental Activity through the Share Payment Date or commit an act constituting Cause through the termination date. 2008 RSUs will convert to shares of common stock, and such shares will be delivered as soon as practicable following the Share Payment Date, but not later than December 31, 2011.</p> <p>Involuntary Termination without Cause: Participants will become entitled to 100% of their 2008 RSUs on the Share Payment Date, provided they do not engage in Detrimental Activity through that date or commit an act constituting Cause prior to the termination date. 2008 RSUs will convert to shares of common stock, and such shares will be delivered as soon as practicable after the Share Payment Date but not later than December 31, 2011.</p> <p>Involuntary Termination with Cause: Participants will forfeit 100% of their 2008 RSUs.</p>
Termination due to Death or Disability	All 2008 RSUs will immediately vest, and shares will be delivered 30 days following the termination date.

NOTE: Notwithstanding the above, bonus-eligible employees whose employment ends for any reason (voluntary or involuntary termination) prior to November 30, 2008 will forfeit all July RSUs. In such cases, “Full Career” treatment does not apply.

EXHIBIT F: GLOSSARY OF SELECT TERMS

“Appropriate Officer” means the Chief Executive Officer or Chief Operating Officer of Holdings (or their respective designees).

“Cause” means a material breach by a person of an employment contract between the person and Holdings or any subsidiary, failure by a person to devote substantially all business time exclusively to the performance of his or her duties for Holdings or any subsidiary, willful misconduct, dishonesty related to the business and affairs of Holdings or any subsidiary, conviction of a felony or a misdemeanor constituting a statutory disqualification under U.S. securities laws (or failure to contest prosecution for a felony or such a misdemeanor), habitual or gross negligence in the performance of a person's duties, solicitation of employees of Holdings or any subsidiary to work at another company, improper use or disclosure of confidential information, the violation of policies and practices adopted by Holdings or any subsidiary including, but not limited to the Code of Conduct, or a material violation of the conflict of interest, proprietary information or business ethics policies of Holdings or any subsidiary, or such other circumstances as may be determined in the sole discretion of an Appropriate Officer. For avoidance of doubt, for purposes of the preceding sentence, a material breach of an employment contract or violation of policies would include, as applicable, the employee's violation of any policy or employment agreement relating to the obligation to provide advance notice of resignation from Holdings or any subsidiary.

“Competitive Activity” means involvement (whether as employee, proprietor, consultant or otherwise) with any person or entity (including any company and its affiliates) engaged in any business activity which is materially competitive with any business carried on by Holdings or any of its subsidiaries or affiliates on the date of termination of a person's employment with Holdings and any of its subsidiaries, as determined in the sole discretion of an Appropriate Officer.

“Detrimental Activity” means (i) using information received during a person's employment with Holdings or any of its subsidiaries related to the business affairs of Holdings or any of its subsidiaries, affiliates or their clients, in breach of such person's undertaking to keep such information confidential; (ii) directly or indirectly persuading or attempting to persuade, by any means, any employee of Holdings or any of its subsidiaries or affiliates to terminate employment with any of the foregoing or to breach any of the terms of his or her employment with the foregoing; (iii) directly or indirectly making any statement that is, or could be, disparaging of Holdings, its subsidiaries or affiliates, or any of their employees (except as necessary to respond truthfully to any inquiry from applicable regulatory authorities or to provide information pursuant to legal process); (iv) violating policies and practices adopted by Holdings or any subsidiary; (v) materially breaching any contract between the person and Holdings or any subsidiary; or (vi) directly or indirectly engaging in any activity that is, or could be, substantially injurious to the financial condition, reputation, or goodwill of Holdings or its subsidiaries or affiliates, in each case as determined in the sole discretion of the Chief Executive Officer or Chief Operating Officer of Holdings (or their respective designees). Notwithstanding the foregoing, if following any termination of employment other than for Cause but prior to the scheduled Share Payment Date it is determined that an act constituting Cause has occurred which was not determined by Holdings (or its designee) at the time of such termination, such act shall also be deemed to constitute Detrimental Activity.

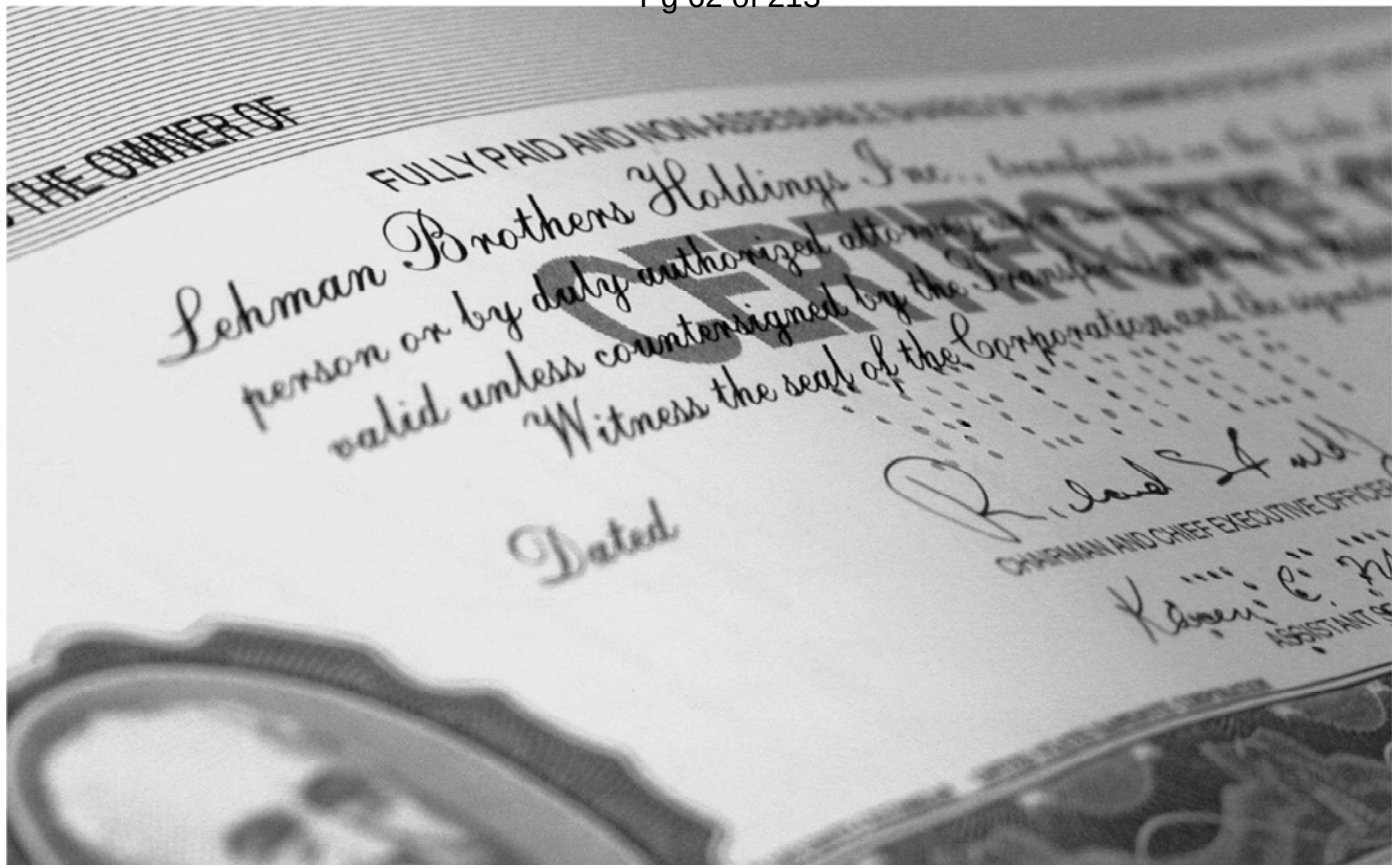
“Disability” means a disability under both the Lehman Brothers Long-Term Disability Insurance Plan and the Social Security Act.

“Full Career Termination” means a Termination of employment with Holdings or any subsidiary when (a) a person has at least 20 years of service; (b) the person is at least 45 years old, and the person has at least 10 years of service with Holdings or any subsidiary; or (c) the person is at least 50 years old, and the person has at least 5 years of service with Holdings or any subsidiary.

“Restricted Stock Units (RSUs)” An RSU represents the conditional right to receive one share of Lehman Brothers common stock three years after the grant date, on November 30, 2011. Generally, RSUs cannot be sold, traded, pledged or transferred during that three-year period.

“Termination” means the end of employment with Holdings or a subsidiary. The characterization of the circumstances of Termination is determined in the sole discretion of an Appropriate Officer.

EXHIBIT C



2007 EQUITY AWARD PROGRAM

L I F E @ L E H M A N

YOUR BENEFITS AND LIFE BALANCE

For Bonus-Eligible Employees and
Production-Based Employees

LEHMAN BROTHERS

DECEMBER 31, 2007 EQUITY AWARD PROGRAM



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This brochure describes significant features of the Lehman Brothers Equity Award Program for 2007. It is not intended to replace the award agreement or other official plan documents. This brochure should be read in conjunction with the other award documents.

ELIGIBILITY

Active employees of the Firm (both bonus-eligible and production-based) hired on or before November 30, 2007, including employees on an approved leave of absence, are eligible to receive an equity award for 2007. Note that eligibility to receive an equity award is subject to a 5-share minimum.

If a production-based employee terminates employment prior to November 30, 2007, the 2007 equity award is based on the amount of production-based compensation accrued for the 2007 equity award through the date of termination, in accordance with the Firm's standard formula for the payout of equity-based compensation for employees at the applicable level. The disposition of the equity award is subject to the termination provisions on page 5.

HOW THE EQUITY AWARD PROGRAM WORKS

The Equity Award Program provides members of Lehman Brothers with a direct ownership interest in the Firm over time. In doing so, the Program gives each of us an incentive to think and act like an owner every day, and allows us to share in the Firm's financial success over time. Your 2007 equity award is awarded to you as a portion of your 2007 compensation.

Employees receive a portion of their total compensation (combined base salary, bonus, production payout, and other applicable forms of compensation) in the form of conditional equity awards. For 2007, the equity award is in the form of restricted stock units ("RSUs") for all employees and will be granted in early December. Each RSU represents the conditional right to receive one share of Lehman Brothers Holdings Inc. common stock five years after the grant date, on or about November 30, 2012. You can consider the RSUs as shares of Lehman Brothers common stock which you will be entitled to receive at that time, provided you meet certain terms and conditions. The 2007 RSUs cannot be sold, traded, or pledged for that five-year period.

The Size of Your Award

The details of your 2007 equity award are shown on your year-end compensation worksheet and will also be available on the Personal Award Summary section of the Equity Award Program site on LehmanLive, keyword [EquityAward](#), before the end of the first quarter of 2008. The amount of each employee's award is determined according to a

schedule that specifies the awards granted at each level of compensation and corporate title. Under this schedule, the amount of compensation awarded in the form of conditional equity awards (RSUs) increases as total compensation rises.

Bonus-Eligible Employees: Your 2007 award will be based on your 2007 total compensation, which includes salary earned in fiscal year 2007 plus any additional compensation with respect to fiscal year 2007, even if some of these payments are deferred or paid in 2008. Such compensation includes 2007 bonus, commissions, and other compensation.

Production-Based Employees: Similar to bonus-eligible employees, you receive a year-end 2007 conditional equity award as a portion of your 2007 total compensation. Your 2007 equity award accrues on a monthly basis, as a portion of your total payout on gross production during December 2006 through November 2007 (paid from January through December 2007) after all adjustments. For 2007, the portion of your total payout in cash (such as cash commissions) and the portion accrued in conditional equity awards were based on the award schedule previously communicated to you. (A copy of the 2007 Equity Award Schedule appears on page 3.) The 2007 payout may have included regular production payout, certain special payments, and other production payout. During any period you are paid a draw, equity (in the form of RSUs) may be awarded with respect to the amount of the draw. If the draw ends and you have earned production payout in excess of the draw, a portion of the excess ("overage") is paid in cash and a portion is accrued toward a year-end equity award (in the year in which overage is accrued). Note that for purposes of this communication, all references to payout or compensation assume compensation payments that are equity eligible only.

The Firm-Provided Discount

The number of RSUs you receive for the Firm's 2007 fiscal year will be based on the closing price of Lehman Brothers Holdings Inc. common stock on the grant date, less a discount: 30% for MDs and 25% for all other employees.

For MDs, with a 30 percent discount, every \$100 of RSUs awarded results in a total RSU award of \$143; for other employees, with a 25 percent discount, every \$100 of RSUs awarded results in a total RSU award of \$133. The discount really means that the Firm "grosses up" your non-discounted portion at the outset.



How Will the Grant Price for My 2007 RSUs Be Determined?

The grant price will be determined based on the closing price of Lehman Brothers Holdings Inc. common stock on the New York Stock Exchange on a date in early December as determined by the Compensation and Benefits Committee of the Board of Directors. The grant price, along with the number of RSUs granted to you, will be communicated as part of the employee year-end compensation discussion with your manager. For Production-based employees, please refer to the "Compensation Statement" within the Sales Compensation System or contact the Compensation Department in New York at (212) 526-8346.

When Will I Receive Shares of Stock?

In general, the vested portion of your 2007 RSUs will convert to shares of Lehman Brothers Holdings Inc. common stock and will be delivered to you on November 30, 2012, subject to the terms and conditions of the Program. See the sections entitled *Termination Provisions* and *Change In Control ("CIC") Provisions* for further information on share delivery.

When Will My 2007 RSUs Vest?

The vesting schedule for your 2007 RSUs is consistent with last year's. For vesting purposes, you should consider your 2007 RSU award as having two components: the **principal portion** and the **discount portion**. The principal portion represents the number of RSUs awarded as part of your 2007 total compensation before the discount. The discount portion represents the balance of your RSU award, provided by the Firm. Your 2007 RSUs will vest in accordance with the schedule below provided you remain actively employed with the Firm through the applicable vesting date:

	Principal	Discount
MDs	35% on November 30, 2010 35% on November 30, 2012	30% on November 30, 2012
Up to and including SVPs	75% on November 30, 2009	25% on November 30, 2012

If your employment with the Firm terminates prior to November 30, 2012, you generally will forfeit the portion of your 2007 RSUs that are unvested at the time of your termination. In addition, if your employment is terminated by the Firm with Cause, or if you engage in Detrimental Activity, prior to November 30, 2012, all of your outstanding RSUs, whether vested or not, will be forfeited. Please refer to page 6 for the definition of Detrimental Activity.

Please refer to the *Termination Provisions* on page 5 for a detailed explanation of how your RSUs may be affected if you leave Lehman Brothers, including the circumstances under which you may forfeit your RSUs.



2007 EQUITY AWARD SCHEDULE

The participation schedule for 2007 is shown below. This schedule reflects the percentage of 2007 total compensation ("TC") that represents the principal portion of your 2007 RSUs. For production-based employees, the participation schedule for 2007 below is the same as the one previously communicated in 2006. An example of the calculations follows.

2007 Equity Award Schedule

Amount of Total Compensation ("TC") in Equity-Based Awards

Total Compensation Range	Employees Through Vice President Level	Senior Vice Presidents	Managing Directors
\$0 - \$74,999	1.15% of 2007 TC	2.3% of 2007 TC	2.3% of 2007 TC
\$75,000 - \$99,999	2.3% of 2007 TC	2.3% of 2007 TC	2.3% of 2007 TC
\$100,000 - \$199,999	\$2,300 plus 6.9% of 2007 TC over \$100,000	\$2,300 plus 6.9% of 2007 TC over \$100,000	\$2,300 plus 6.9% of 2007 TC over \$100,000
\$200,000 - \$299,999	\$9,200 plus 11.5% of 2007 TC over \$200,000	\$9,200 plus 11.5% of 2007 TC over \$200,000	\$9,200 plus 11.5% of 2007 TC over \$200,000
\$300,000 - \$499,999	\$20,700 plus 17.25% of 2007 TC over \$300,000	\$34,500 plus 18.687% of 2007 TC over \$300,000	\$34,500 plus 18.687% of 2007 TC over \$300,000
\$500,000 - \$749,999	\$55,200 plus 23% of 2007 TC over \$500,000	\$71,875 plus 23% of 2007 TC over \$500,000	\$71,875 plus 23% of 2007 TC over \$500,000
\$750,000 - \$999,999	\$112,700 plus 28.75% of 2007 TC over \$750,000	\$129,375 plus 40.25% of 2007 TC over \$750,000	\$129,375 plus 40.25% of 2007 TC over \$750,000
\$1,000,000 - \$1,499,999	\$192,600 plus 36% of 2007 TC over \$1.0 million	\$240,000 plus 42% of 2007 TC over \$1.0 million	\$240,000 plus 52.8% of 2007 TC over \$1.0 million
\$1,500,000 - \$1,999,999	\$372,600 plus 42% of 2007 TC over \$1.5 million	\$450,000 plus 54% of 2007 TC over \$1.5 million	\$504,000 plus 67.2% of 2007 TC over \$1.5 million
\$2,000,000 - \$2,499,999	\$582,600 plus 48% of 2007 TC over \$2.0 million	\$720,000 plus 66% of 2007 TC over \$2.0 million	\$840,000 plus 72% of 2007 TC over \$2.0 million
\$2,500,000 and up	\$822,600 plus 54% of 2007 TC over \$2.5 million up to a max of 36% of 2007 TC	42% of 2007 TC	\$1,200,000 plus 75% of 2007 TC over \$2.5 million to a max of 50% of 2007 TC

Award Calculation Example

Using the Equity Award Schedule above, your 2007 equity award will be determined at year end based on your 2007 total compensation. Sample illustrations are shown below.

	Employees thru VP Level	SVPs	MDs
2007 Total Compensation	\$100,000	\$500,000	\$1,000,000
Amount of Compensation in RSUs:	\$2,300	\$71,875	\$240,000
Est. FMV on grant date ¹ :	\$63.49	\$63.49	\$63.49
Discount:	25%	25%	30%
Est. Discounted grant price:	\$47.62	\$47.62	\$44.44
Est. Total # of RSUs:	48	1,509	5,400
Principal Portion:	36	1,132	3,780
Discount Portion:	12	377	1,620
Total Grant Value with Discount:	\$3,067	\$95,833	\$342,857

¹ Based on closing price of Lehman Brothers common stock on November 13, 2007. Actual grant price will be determined in early December.

Note: The number of RSUs has been rounded to the nearest whole number for illustrative purposes only. The actual grant price for 2007 RSUs will be determined based on the closing price of Lehman Brothers Holdings Inc. common stock on the New York Stock Exchange on a date to be determined in early December.



2007 Monthly Equity Accrual for Production-Based Employees

As an example, below is the monthly calculation for a production-based employee whose total compensation earned for production months December 2006 to November 2007 (paid January to December 2007) is \$100,000.

Step	Instructions	Sample Calculation	Sample Result
Step 1	Take YTD Total Compensation for first month, annualize (multiply by 12) and divide by production month number.	$\$7,000 \times 12 \div 1$	\$84,000
Step 2	Calculate projected award from 2007 Equity Award Schedule.	\$1,932	\$1,932
Step 3	Multiply result by allocation %. Subtract previous month's YTD equity accrual from result. This is the monthly equity accrual.	$(\$1,932 \times 8.33\%) - \0	\$161
Step 4	Take YTD Total Compensation for second month, multiply by 12 and divide by production month number.	$\$15,000 \times 12 \div 2$	\$90,000
Step 5	Calculate projected award from 2007 Equity Award Schedule.	\$2,070	\$2,070
Step 6	Multiply result by allocation %. This is the YTD equity accrual. Subtract previous month's YTD equity accrual from result. This is the monthly equity accrual.	$(\$2,070 \times 16.67\%) - \161	\$184
Step 7	Repeat for next month.		

#	Pay Month	Monthly Total Comp.	YTD Total Comp.	Annualized Total Comp.	Projected Equity Award	Allocation %	YTD Equity Accrual	Monthly Equity Accrual
1	January	\$7,000	\$7,000	\$84,000	\$1,932	8.33%	\$161	\$161
2	February	8,000	15,000	90,000	2,070	16.67%	345	184
3	March	10,000	25,000	100,000	2,300	25.00%	575	230
4	April	7,500	32,500	97,500	2,243	33.33%	748	173
5	May	9,500	42,000	100,800	2,355	41.67%	981	234
6	June	7,000	49,000	98,000	2,254	50.00%	1,127	146
7	July	7,500	56,500	96,857	2,228	58.33%	1,300	173
8	August	10,500	67,000	100,500	2,335	66.67%	1,556	257
9	September	8,000	75,000	100,000	2,300	75.00%	1,725	169
10	October	8,500	83,500	100,200	2,314	83.33%	1,928	203
11	November	6,500	90,000	98,182	2,258	91.67%	2,070	142
12	December	10,000	100,000	100,000	2,300	100.00%	2,300	230
Total								\$2,300

In the example above, \$2,300 is the amount of total compensation accrued by the production-based employee toward the year-end RSU award. For the calculation of the number of RSUs (including principal and discount portion), see example on page 3. **Note that if a production-based employee terminates employment prior to November 30, 2007, the 2007 equity award is based on the amount of production-based compensation accrued for the 2007 equity award through the date of termination, in accordance with the Firm's standard formula for the payout of equity-based compensation for employees at the applicable level. The disposition of the equity award is subject to the termination provisions on page 5.**



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ERMINATION PROVISIONS

All Employees	
Voluntary Termination (but not Full Career)	Participants will forfeit all unvested 2007 RSUs. Any vested 2007 RSUs will convert to shares of common stock and such shares will be delivered as soon as practicable after November 30, 2012 (the "Share Payment Date") but not later than December 31, 2012, provided the participant does not engage in Detrimental Activity through that date and has not committed an act constituting Cause through the termination date.
Involuntary Termination (but not Full Career)	<p>Involuntary Termination without Cause: Participants will become entitled to the principal portion of their award, including the unvested principal portion (provided the employee signs a Firm-standard release agreement). The discount portion will be forfeited. Shares for the principal portion will be delivered as soon as practicable after the Share Payment Date, but not later than December 31, 2012, provided the participant does not engage in Detrimental Activity through that date.</p> <p>Involuntary Termination with Cause: Participants will forfeit 100% of the principal and discount portions of RSUs.</p>
Full Career Termination	<p>A termination is "Full Career" if:</p> <ul style="list-style-type: none"> ■ The participant has at least 20 years of service; or ■ The participant is at least 45 years old and has at least 10 years of service; or ■ The participant is at least 50 years old and has at least 5 years of service. <p>Voluntary Termination: Participants will become entitled to 100% of both the 2007 RSU principal and discount portions on the Share Payment Date, provided they do not engage in Competitive Activity through the end of the fiscal quarter following the one year anniversary of the termination date, and do not engage in Detrimental Activity through the Share Payment Date or commit an act constituting Cause through the termination date. 2007 RSUs will convert to shares of common stock, and such shares will be delivered as soon as practicable following the Share Payment Date, but not later than December 31, 2012.</p> <p>Involuntary Termination: Participants will become entitled to 100% of both the 2007 RSU principal and discount portions on the Share Payment Date, provided they do not engage in Detrimental Activity through that date or commit an act constituting Cause prior to the termination date. 2007 RSUs will convert to shares of common stock, and such shares will be delivered as soon as practicable after the Share Payment Date but not later than December 31, 2012.</p>
Termination due to Death or Disability	Entire principal and discount portions will immediately vest, and shares will be delivered 30 days following the termination date. "Disability" means a disability under both the Lehman Brothers Long-Term Disability Insurance Plan and the Social Security Act.



YOUR CONDUCT WITH RESPECT TO LEHMAN BROTHERS AFTER YOU LEAVE

You may forfeit your rights to any 2007 RSUs (and related dividend reinvestment) if you engage in Competitive Activity (for Full Career employees) or Detrimental Activity or if you commit an act constituting Cause prior to your termination of employment.

Cause

"Cause" means a material breach by a person of an employment contract between the person and Holdings or any subsidiary, failure by a person to devote substantially all business time exclusively to the performance of his duties for Holdings or any subsidiary, willful misconduct, dishonesty related to the business and affairs of Holdings or any subsidiary, conviction of a felony or of a misdemeanor constituting a statutory disqualification under United States securities laws (or failure to contest prosecution for a felony or such a misdemeanor), habitual or gross negligence in the performance of the person's duties, solicitation of employees of Holdings or any subsidiary to work at another company, improper use or disclosure of confidential information, the violation of policies and practices adopted by Holdings or any subsidiary including but not limited to the Code of Conduct, or a material violation of the conflict of interest, proprietary information or business ethics policies of Holdings or any subsidiary, or such other circumstances as may be determined in the sole discretion of an Appropriate Officer. For avoidance of doubt, for purposes of the preceding sentence, a material breach of an employment contract or violation of policies would include, as applicable, the employee's violation of any policy or employment agreement relating to the obligation to provide advance notice of resignation from Holdings or any subsidiary.

Competitive Activity

"Competitive Activity" means involvement (whether as an employee, proprietor, consultant or otherwise) with any person or entity (including any company and its affiliates) engaged in any business activity which is materially competitive with any business carried on by Lehman Brothers Holdings Inc. or any of its subsidiaries or affiliates on the date of termination of a person's employment with the Firm, as determined in the sole discretion of the Chief Executive Officer or the Chief Operating Officer of the Firm (or their respective designees).

Please note that the determination of Competitive Activity is not based on the function that an individual performs in a company but rather the nature of the company's businesses. Asset management companies, mortgage-related companies, private equity firms, and hedge funds, along with investment banks, commercial banks, small boutique-type firms and most other financial services companies, are considered competitors of the Firm for purposes of the Equity Award Program.

While the Firm values its client relationships with financial institutions, these relationships will not preclude companies being deemed competitors when any of their business activities may be considered competitive with the Firm. Please consult your Human Resources representative or the Compensation Department if you have questions about a particular company.

Detrimental Activity

"Detrimental Activity" means at any time (i) using information received during a person's employment with Holdings or any of its subsidiaries relating to the business affairs of Holdings or any of its subsidiaries, affiliates or clients, in breach of such person's undertaking to keep such information confidential; (ii) directly or indirectly persuading or attempting to persuade, by any means, any employee of Holdings or any of its subsidiaries or affiliates to terminate employment with any the foregoing or to breach any of the terms of his or her employment with the foregoing; (iii) directly or indirectly making any statement that is, or could be, disparaging of Holdings, its subsidiaries or affiliates, or any of their employees (except as necessary to respond truthfully to any inquiry from applicable regulatory authorities or to provide information pursuant to legal process); or (iv) directly or indirectly engaging in any activity that is, or could be, substantially injurious to the financial condition, reputation or goodwill of Holdings or its subsidiaries or affiliates, in each case as determined in the sole discretion of the Chief Executive Officer or the Chief Operating Officer of the Firm (or their respective designees).

TAX CONSIDERATIONS

Tax Treatment of Your 2007 RSUs

Under current U.S. Federal tax law, you will not be taxed on the value of your RSUs until shares of common stock are delivered. As a result, your RSUs (including dividend reinvestment RSUs—refer to page 7) appreciate on a pre-tax basis until they



convert to shares of common stock. Provided below is a summary of the taxes related to RSUs that are ultimately due under current law.

Note: Pursuant to current tax law, if you work in more than one tax jurisdiction during the 5-year restriction period (from the date of grant through the conversion date for RSUs), you and/or the Firm may have a tax reporting requirement and/or tax withholding obligation and/or actual tax liability with respect to each such jurisdiction. The income attributed to a specific tax jurisdiction will be calculated for tax withholding and reporting purposes based on the relevant employment period in each location during the applicable period.

Taxation of RSUs

- No taxation on the award date.
- Upon delivery of common stock, the fair market value of the shares will be treated as employment income based on the closing price of Lehman Brothers Holdings Inc. common stock on the delivery date.
- This income will be subject to applicable tax withholding.
- Special provisions dealing with capital gains will not apply upon delivery of common stock.
- If you retain your shares after delivery, the basis for capital gains is the closing price on the delivery date.

Consult your personal tax advisor concerning the application of all US federal/state/local or foreign tax laws on your RSUs.

CHANGE IN CONTROL ("CIC") PROVISIONS

Following a CIC, except to the extent that they would otherwise vest earlier, vesting of RSUs (both principal and discount portions) will accelerate to the later of: (i) 18 months following the CIC; or (ii) the end of the fiscal year in the year after the CIC occurs (the "CIC Vesting Date"), provided you remain actively employed through that date. Shares of Lehman Brothers common stock will be delivered on the earlier of the CIC Vesting Date or November 30, 2012, provided you do not engage in Detrimental Activity.

If your employment is terminated involuntarily without Cause following the CIC but prior to the CIC Vesting Date, all RSUs (both principal and discount portions) become immediately vested.

If your employment terminates for any reason (other than for Cause) following a CIC, any of your then vested RSUs (including those that may vest by reason of your involuntary termination) will convert to shares and be delivered on the earlier of: (i) the end of the fiscal quarter 1 year following the termination date; (ii) the CIC Vesting Date; or (iii) November 30, 2012, provided you do not engage in Detrimental Activity.

DIVIDEND EQUIVALENTS

Dividend equivalents accrue quarterly on your RSUs and are reinvested as additional RSUs, without a discount. Dividend reinvestment RSUs are subject to the same vesting and forfeiture provisions as the underlying RSUs to which they relate. The Firm retains the discretion to change this dividend policy at any time to pay in cash rather than RSUs.

VOTING RIGHTS

Lehman Brothers established a Trust and funded it with shares for your benefit to provide you with voting rights related to your RSU awards. You will be able to direct the voting related to shares held in the Trust in proportion to the number of RSUs you hold. You will continue to have these voting rights as long as you remain employed with the Firm.

OTHER INFORMATION

This document is intended as a brief summary of the material terms of the 2007 Equity Award Program. This document does not purport to summarize or describe the terms of equity awards from prior years. In the event of any conflict or discrepancy between the plan documents (including, but not limited to, the Restricted Stock Unit Award Agreement, the 2005 Stock Incentive Plan, and the 2005 Stock Incentive Plan Prospectus applicable to these awards) and the information in this summary, the plan documents will govern.

Nothing in this summary or the plan documents shall be construed to create or imply any contract of employment between you and Lehman Brothers.

All references to taxation in this summary refer to U.S. Federal taxes and current tax law. You should consult your local tax authorities or personal tax consultant for details on the impact of tax laws in effect at the time your RSUs become taxable.

If you have any questions about the Program in general, your personal award summary or your award agreement, visit the Equity Award Program site on LehmanLive, keyword [EquityAward](#), or contact the Compensation Department at 212-526-8346 (5-8346) or by e-mail at compensation@lehman.com.



EXHIBIT D

2008 Summary Plan Description

Effective: 1 January 2008

Medical, Dental, Vision Care, Flexible Spending Accounts, Life and Disability

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Introduction

This booklet is intended to be a Summary Plan Description for the **Lehman Brothers Holdings Inc. Group Benefits Plan** the “Plan”). The Plan includes group medical, dental and vision coverages, flexible spending accounts, life and accident insurance and long and short term disability coverage. You are entitled to a hard copy of this Summary Plan Description free of charge. Active employees may print all or parts of the booklet on Lehman Brothers printers. In addition, participants, beneficiaries, dependents and any of their legal representatives may request a hard copy of this booklet by calling the Lehman Brothers Global HR Service Center (HR Service Center) at 5-2363 (212-526-2363).

This summary plan description summarizes the benefits available to U.S. benefits-eligible employees (see the Who is Eligible for these Benefits section below) and, in the case of the Medical Plan, includes the portion of the Plan document defining the available benefits. ***Your participation and the benefits to which you are entitled under the plan are subject to the terms and provisions of the applicable plan documents and, in the case of a conflict between this booklet and the plan documents, the plan documents will govern.***

In describing your benefits, we have tried to avoid using the technical words and phrases used in the governing legal documents. However, the official legal documents must remain the final authority in the administration of these benefits. You may examine the legal documents by contacting the HR Service Center at 5-2363 (212-526-2363).

Right to Amend or Terminate

Lehman Brothers reserves the right to change or discontinue any of these benefits and programs at any time without prior notice. This includes, but is not limited to, the level of benefits, eligibility for benefits and any cost to participants.

Who Is Eligible for These Benefits

To be a “U.S. benefits-eligible employee” you must be:

- An active employee of Lehman Brothers Holdings Inc., Lehman Brothers Inc. or a participating affiliate (a list of participating affiliates is available from the HR Service Center); and
- A salaried employee, hourly employee or commissioned Investment Representative on the U.S. payroll who is regularly scheduled to work 20 hours or more per week; and
- If you are based outside of the United States, you must be subject to U.S. income and Social Security taxes.

You are not eligible if you are:

- An hourly employee working less than 20 hours per week, or
- An employee on seasonal or temporary assignment or you are employed in a special purpose program (such as student intern), or
- A leased employee, or an employee who performs services for Lehman Brothers under an arrangement in which you are treated as a consultant, an independent contractors or an employee of another entity.

Enrollment

As a new or newly benefits eligible employee, you may elect coverage within 31 days of your date of hire or date of eligibility, whichever is later. If you do not make an election within 31 days of becoming eligible you will only have coverage in the programs that are 100% company-paid. Your next opportunity to enroll in the Medical, Dental, Vision Care and/or Flexible Spending Account plans will be during the annual Open Enrollment period (usually from mid-October through mid-November), for coverage effective the following January 1. If you have a qualified family status change, you may be eligible to elect coverage prior to the Open Enrollment period. See the “Mid-year Changes to Coverage” section for more details.

You may choose a different level of coverage (individual, individual + one, or family) for each Plan. For example, a married employee with a newborn baby may choose “Family” coverage under the Medical Plan (to cover all 3 family members), “Employee Plus One” under the Dental Plan (to only cover the employee and the spouse), and choose to only enroll the spouse in the Vision Care Plan. Please consult the specific plan sections for information on each plan’s enrollments rules.

Please review the appropriate section of this document for details on your enrollment opportunities in the programs that are not part of the annual Open Enrollment period.

To enroll, access the e-Benefits Web page within the Benefits section of Lehman & You.

Mid-year Changes to Coverage

Because your Medical, Dental, Vision Care, and Flexible Spending Account plan employee contributions are made on a pre-tax basis, the Internal Revenue Code requires that your coverage election stay in effect throughout the full Plan Year unless you have experienced a “qualified family status change.” If you have experienced a qualified family status change, you have 31 days from the qualifying event to change your coverage election. Your change (enrollment, change in coverage type or cancellation) must correspond with the Family Status event.

If one of these events occurs you have 31 days from the date of that event to make a change in your benefit elections. You must contact to the HR Service Center via e-mail at HRServices@lehman.com or fax a memo to the HR Service Center at 646-758-5200. You must include your social security number, the qualifying event and date the event occurred. The HR Service Center will e-mail you a link that will allow you to make your elections online.

The chart on page 5 lists the types of events that may qualify as a family status change and the corresponding coverage changes you can elect. A coverage change must be consistent with the qualified family status change. For example, if your spouse or domestic partner loses medical coverage you may increase your medical coverage level (adding dependents) or enroll for the first time, but you may not decrease your coverage level or cancel coverage. Another example of a coverage change that is consistent with a qualified family change would be if you adopt a child, you may enroll the child and yourself or other family members in the Medical Plan, but you cannot drop coverage or only enroll yourself.

Qualified Family Status Changes

Family Status Change	Allowable Coverage Changes
Entering a domestic partnership	<ul style="list-style-type: none"> • Enrollment of domestic partner
Divorce, legal separation or death of spouse	<ul style="list-style-type: none"> • Enrollment of employee and/or dependents, if previously covered under spouse's plan • Cancellation of spouse's coverage
Termination of domestic partnership or death of domestic partner	<ul style="list-style-type: none"> • Enrollment of employee and/or dependents, if coverage under Plan originally declined due to coverage under domestic partner's plan • Cancellation of domestic partner's coverage
Birth or adoption of a child (including initiation of adoption proceedings); legal guardianship of a child	<ul style="list-style-type: none"> • Enrollment of child • Enrollment of employee/dependents together with child
Spouse becomes unemployed, loses coverage or takes unpaid leave of absence.	<ul style="list-style-type: none"> • Enrollment of employee, spouse or dependents, if previously covered under spouse's plan
Domestic partner becomes unemployed, loses coverage or takes unpaid leave of absence	<ul style="list-style-type: none"> • Enrollment of domestic partner, if previously covered under domestic partner's plan • Enrollment of employee or dependents, if coverage under Plan originally declined due to coverage under domestic partner's plan
You take unpaid leave of absence	<ul style="list-style-type: none"> • Cancellation of all coverage • Decrease your coverage level (e.g. from employee plus one to single coverage level or from family to employee plus one or single)
Dependent child returns to school full-time	<ul style="list-style-type: none"> • Add coverage for the child
Death of a dependent	<ul style="list-style-type: none"> • Enrollment of employee and/or dependents, if previously covered under dependent's plan • Cancellation of deceased dependent's coverage
Spouse becomes employed and/or becomes eligible for family coverage	<ul style="list-style-type: none"> • Cancellation of employee and/or dependent coverage, if coverage obtained under domestic partner's plan
Domestic partner becomes employed and/or becomes eligible for family coverage	<ul style="list-style-type: none"> • Cancellation of employee, dependent and/or domestic partner's coverage, if coverage obtained under domestic partner's plan

Definition of a Dependent

For the Medical Plan, Dental Plan, Vision Care Plan and Group Term Life Insurance Program, eligible dependents include those listed below. For the Flexible Spending Accounts and Voluntary Group Accident Plan, eligible dependents are defined separately. See the summaries of those plans for details.

- Your legal spouse or domestic partner. A domestic partner is any person who resides with you and with whom you have a currently registered domestic partnership with a governmental body pursuant to state or local law authorizing such registration. In the absence of a formal registration, you can register your domestic partnership by filing a Declaration of Domestic Partnership with the HR Service Center.
- Your unmarried children up to age 19 years if they live with you for more than ½ the year and do not provide more than ½ of their own support, or if you claim them as a dependent on your federal income tax return. (The term “children” includes your own child, legally adopted child, child for whom legal adoption proceedings have been initiated, foster child or child for whom you have been named legal guardian.) Coverage ends December 31, following or coincident with the child’s 19th birthday or at the end of the month in which a child graduates, marries or is providing more than ½ of their own support, whichever event occurs first.
- Your unmarried children up to age 24 (25 if you claim them as a tax dependent) if they are enrolled full-time in an accredited institution of higher learning and they do not provide more than ½ of their own support. Eligibility for coverage will cease (a) at the end of the month in which a child graduates, marries, provides over ½ of their own support, or no longer attends school, regardless of age, or (b) for 25 year old children, the end of the month in which you file a federal income tax return that does not claim the child as a dependent, or (c) the December 31 following or coincident with the child’s 25th birthday, whichever event occurs first.
- Your unmarried, fully handicapped child, regardless of age, who is totally and continuously disabled and who is incapable of self-sustaining employment by reason of a mental or physical handicap (as approved by Aetna), who does not provide more than ½ of their own support and who lives with you for more than ½ the year, and who became incapacitated prior to attaining the maximum dependent age indicated above. Please contact the HR Service Center at 5-2363 (212-526-2363) for further information. To submit an application to Aetna, two forms must be completed; one by the member and one by the disabled child’s physician. Both are to be submitted to Aetna for consideration. Eligibility for coverage will cease when Aetna deems that the child is no longer fully handicapped.

Stepchildren or the children of your domestic partner who meet the above requirements qualify as dependents when they are unmarried and are primarily dependent on you and your spouse or domestic partner for maintenance and support. In addition, you and your spouse or domestic partner must have financial responsibility for the child. If financial responsibility was determined by a court (such as in a divorce action) the decision of the court will govern.

A child of divorced or separated parents will be considered the dependent of both parents regardless of who can claim the tax exemption as long as the parents provide over half of the child’s support.

No person can be covered as both an employee and a dependent, and no person may be covered as a dependent of more than one employee.

Whose Plan is Primary?

When both parents are employed and each is covered under a different group medical plan at work, the employer's plan always pays first; that is, your primary plan is the one through your employer and your spouse or domestic partner's primary plan is the one through his or her employer. You may apply through your spouse or domestic partner's plan for secondary coverage and he or she can do the same through your plan, but each must first apply to his or her own group plan. See the "Coordination with Other Group Medical Plans" sections for further information on how secondary coverage works under the Medical Plan. If children are covered under both parents' plans, the determination of primary coverage is not based on a parent's age but on whose birth date falls earliest in the calendar year. For example, if the mother's birth date is January 6 and the father's birth date is July 8, the mother's coverage is primary, regardless of who is older.

For stepchildren or the children of your domestic partner, if there is no court decree specifying whose coverage is primary, the following rules will apply:

- If the parent with custody is not married or does not live with a domestic partner, the custodial parent's medical plan will be the child's primary carrier and the parent without custody will carry secondary benefits.
- If the parent with custody is married or lives with a domestic partner, the medical plan of that parent is primary; the medical plan of the stepparent or domestic partner living with him or her carries secondary benefits and the medical plan of the parent without custody carries tertiary benefits.

Effect of Qualified Medical Child Support Order

If the Plan receives a Qualified Medical Child Support Order (a "QMCSO") that requires you to provide medical coverage for your dependent children, appropriate deductions for such coverage, beginning as of the date specified in the QMCSO, will be taken from your salary. A QMCSO is a court judgment, decree or order that (a) provides for child support relating to health benefits with respect to the child in such plan, and is ordered under state domestic relations law, or (b) enforces a state medical child support law enacted under Section 1908 of the Social Security Act. The Plan Administrator will notify you if a medical child support order has been received and will determine whether such order is a QMCSO.

Insurance Earnings

Definition of Insurance Earnings

The Firm recalculates your Insurance Earnings once each year, on April 1st, using the following:

- Annualized base salary in effect on December 31st of the prior year;
- Eligible bonuses for the prior year's performance paid through February of the current year, including the discounted value of Restricted Stock Units ("RSUs") awarded as part of the bonus; and
- Production compensation paid in the prior year, including the discounted value of RSUs awarded as part of your production compensation.

The Insurance Earnings calculation is based on gross pre-tax earnings prior to any payroll deductions, including deferrals for the Lehman Brothers Savings Plan and your Flexible Spending Accounts.

Insurance Earnings for New Hires

If you are a new hire, your initial Insurance Earnings are calculated automatically when you enroll in benefits within 31 days of your date of hire.

Salaried Employees

Until the April 1 following your date of hire, a salaried employee will have Insurance Earnings equal to their base salary as of their date of hire. Sign-on bonuses are not included in the calculation of Insurance Earnings.

On the April 1 following your date of hire, a salaried employee's Insurance Earnings will be recalculated according to the Insurance Earnings formula for that year. See the Definition of Insurance Earnings section above.

Commissioned Investment Representatives

Until the April 1 following your date of hire, a commissioned Investment Representative's Insurance Earnings will be \$100,000.

On the April 1 following your date of hire, a commissioned Investment Representative's Insurance Earnings will be calculated to be the greater of \$100,000 or annualized commissions paid during the prior partial calendar year.

For example, a commissioned Investment Representative hired in September 2006 receives commission payments in October, November and December totaling \$20,000. Annualized (divide by 3, multiply by 12) commissions are therefore \$80,000. Since this is less than \$100,000, on April 1, 2007, his or her Insurance Earnings will remain \$100,000 (the initial Insurance Earnings amount for a newly hired commissioned employee).

On the April 1 following the first full calendar year of employment, a commissioned Investment Representative's Insurance Earnings will be recalculated according to the Insurance Earnings formula for that year.

Employment at Will

Your employment is "at will." This means that your employment is for no definite period and can be terminated by you or the Firm for any reason or for no reason at all, with or without notice.

The description of the Plan contained in this Summary Plan Description is for your information. Access to this Summary Plan Description does not create a contract or employment rights and no provisions is a guarantee or a promise of any kind. The Firm may change, supplement, and/or withdraw any or all of the benefits described in this booklet at any time, with or without notice. Accordingly, nothing in this booklet changes your status as an employee "at will."

When Coverage Ends

Generally, your coverage under the Lehman Brothers Group Benefit Plan and/or coverage of your dependents will cease:

- As of midnight on the day your employment terminates or you cease to be a U.S. benefits-eligible employee (see Who Is Eligible for These Benefits); or
- As of midnight on the day a covered dependent no longer meets the definition of an eligible dependent (see Definition of a Dependent); or
- As of the last day of a month when you fail to pay your employee contributions; or
- As of the effective date that you discontinue coverage due to an Open Enrollment election or a “qualified family status change”; or
- When the Plan is terminated by the Firm.

Upon termination of coverage, you and/or your eligible dependents may be entitled to continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986 (“COBRA”). See Continuation of Coverage section for details.

Medical Plan

The **Lehman Brothers Medical Plan** is an open choice point of service plan managed by Aetna, a national leader in health care management. Aetna has established a network of carefully selected health care professionals, who have agreed to accept a negotiated fee for their services. Each provider must meet Aetna's strict standards for professional certification and must abide by Aetna's quality control procedures. Once admitted to the network, doctors are continually re-evaluated. Aetna's re-evaluation procedures include patient satisfaction surveys, audits, on-site visits and re-certification every two years.

Under the Aetna Choice POS II you have two levels of benefits. You may use a network health care provider, (referred to as using the "in-network" benefit). Alternately, you may choose to see a health care provider not affiliated with the network (referred to as using the "out-of-network" benefit). You always have the choice to go in- or out-of-network while you are enrolled in the Plan.

Eligibility and Enrollment

If you are a U.S. benefits-eligible employee, you are eligible to enroll in the Medical Plan. Coverage is available for you and your eligible dependents as of the first day of employment provided you enroll within 31 days of hire. Hourly employees whose status changes to U.S. benefits-eligible must enroll within 31 days of the status change.

U.S. benefits-eligible employees based outside of the United States are eligible for the Aetna Global Benefits Medical Plan.

Please note that you must be enrolled in the Medical Plan to enroll your dependent(s).

Late Enrollment/Open Enrollment

Enrollment in the Medical Plan is not automatic. Employees and/or eligible dependents who do not enroll within 31 days of becoming eligible will not be eligible to enroll until the next annual Open Enrollment period (usually from mid-October through mid-November), with an effective date for coverage the following January 1st.

Use of Insurance Earnings under the Medical Plan

Because the Medical Plan employee contributions, deductibles and out-of-pocket maximums are set on January 1 of each year, they are based on Insurance Earnings calculated the prior April 1. Accordingly, although Insurance Earnings are recalculated each year on April 1, your employee contribution, deductible and out-of-pocket maximum will not change until the first day of the following calendar year.

For example if your Insurance Earnings were calculated as follows:

- April 1, 2007 \$45,000
- April 1, 2008 \$60,000

your 2008 deductible, out-of-pocket maximum and employee contribution are based on the figure calculated in 2007 (\$45,000). The figure calculated in 2008 (\$60,000) will be used to determine your 2009 deductible, out-of-pocket maximum and monthly employee contribution.

Cost of Coverage

Pre-tax Monthly Employee Contributions

While the Firm pays most of the cost of coverage, you will be asked to pay a portion of the expense. Your monthly contribution, paid on a pre-tax basis, is determined by your Insurance Earnings. If you initially elect to cover yourself and one (1) dependent, you must designate the dependent that will be covered and you may not substitute a different dependent at a later point during the year. If you choose “family” coverage, there is no limit to the number of dependents that can be covered, but all dependent must be enrolled during the Open Enrollment period or within 31 days of your date of hire or a qualified family status change. The chart below details the pre-tax payroll deductions for the calendar year 2008.

Insurance Earnings as of January 1, 2008	Coverage Level		
	Individual	Employee Plus One Dependent	Family (Employee Plus Two or More Dependents)
Under \$50,000	\$35	\$71	\$109
\$50,000 – 99,999	53	106	164
\$100,000 – 149,999	71	141	219
\$150,000 – 299,999	88	176	274
\$300,000 – 499,999	106	212	328
\$500,000 – 749,999	124	247	383
\$750,000 and above	141	282	438

Calendar Year Deductibles (Out-of-Network Only)

Before the plan pays benefits for out-of-network medical services, participants must meet a calendar year deductible. Each covered individual must meet his or her calendar year deductible before the Plan begins paying benefits. However, if you have Family coverage, the maximum Family deductible is equal to three times the individual deductible. Expenses applied to the deductible for all family members will be aggregated towards this limit.

Insurance Earnings as of January 1, 2008	Calendar Year Deductible
Under \$50,000	\$400
\$50,000 – 99,999	500
\$100,000 – 149,999	600
\$150,000 – 299,999	700
\$300,000 – 499,999	800
\$500,000 – 749,999	900
\$750,000 and above	1,000

Once the calendar year deductible has been met, the Plan begins reimbursing out-of-network expenses at 70% of reasonable and customary charges.

Calendar Year Out-of-Pocket Maximums

Once a covered individual has met the calendar year out-of-pocket maximum, the Plan begins to pay benefits at 100% of covered expenses. (Deductibles and copays do not count toward the out-of-pocket maximum.) Separate out-of-pocket maximums apply to in- and out-of-network expenses. Each covered individual must meet an out-of-pocket maximum before the Plan will reimburse at 100% of negotiated costs (in-network) or reasonable and customary charges (out-of-network) for that individual.

Insurance Earnings as of January 1, 2008	In-Network	Out-of-Network
Under \$50,000	\$1,000	\$2,000
\$50,000 – 99,999	1,250	2,500
\$100,000 – 149,999	1,500	3,000
\$150,000 – 299,999	1,750	3,500
\$300,000 – 499,999	2,000	4,000
\$500,000 – 749,999	2,250	4,500
\$750,000 and above	2,500	5,000

Medical Plan Benefits at-a-Glance

Plan Provision	In-Network	Out-of-Network
Lifetime Maximum Benefit	Unlimited	
Precertification of In-Patient Hospitalization	Yes	
Office Visits (Primary Care Physician)	100% after \$20 copay ²	70% after deductible
Office Visits (Specialists)	100% after \$30 copay ²	70% after deductible
Choice of Doctors	Network providers only	Any provider
Claim Forms Required	No	Yes
Hospital Services:		
Semi-Private Room & Board	90%, no deductible	70% after deductible
Surgery (in- or out-patient)	90%, no deductible	70% after deductible
X-rays and other Diagnostic Procedures Billed by the Hospital	90%, no deductible	70% after deductible
Emergency Room	90%, no deductible	90%, no deductible
Short-Term Rehabilitation:		
Includes physical, occupational and restorative speech therapy	100% (after \$30 copay ² , if billed as an office visit)	70% after deductible
Benefit Maximum ¹	60 visits per calendar year. Maximum applies to any combination of Outpatient physical, occupational and speech therapy.	
Speech Therapy for Developmental Delays:	Paid as an out-of-network expense: 70% after deductible, in- and out-of-network	
Benefits Maximum ¹	30 visits per calendar year	
Chiropractor	90%, no deductible	70% after deductible
Benefit Maximum ¹	30 visits per calendar year	
Preventive/Wellness Care:		
Routine Physical	100%	70% after deductible
Well-woman Ob/Gyn	100%	70% after deductible
Well-Child Care	100%	70% after deductible
Routine Hearing Exam	100%	70% after deductible
Routine Eye Exam	100%	70% after deductible

Medical Plan Benefits at-a-Glance (continued)

Plan Provision	In-Network	Out-of-Network
Mental Health/Substance Abuse Benefits:		
In-Patient	90%, no deductible ³	70% after deductible ³
Benefit Maximum ¹	30 days per calendar year	
Out-Patient	100% after \$30 copay per visit	70% after deductible ³
Benefit Maximum ¹	50 visits per calendar year	
Prescription Drugs:		
Retail Pharmacy	100% after coinsurance, maximum \$100 Generic: 10% coinsurance Preferred Brand: 25% coinsurance Non-Preferred Brand: 50% coinsurance	Reimbursement will be at the same amount as if prescription was filled at an in-network pharmacy. (See Prescription Drug section for an example)
Mail Order Pharmacy ⁴	100% after coinsurance, maximum \$250 Generic: 10% coinsurance Preferred Brand: 25% coinsurance Non-Preferred Brand: 50% coinsurance	Not Covered
Maternity Care:		
Prenatal Doctor Visits	100%	70% after deductible
Doctor’s Charge for Delivery	90%, no deductible	70% after deductible ⁵
Hospital Charges (semi-private room & board)	90%, no deductible	70% after deductible ⁵
Pediatrician (in-hospital)	90%, no deductible	70% after deductible ⁵
Infertility Treatment:		
Pre-authorization of treatment plan required	Covered as any other medical service: copays apply to office visits; 90% and 70% coverage for other services	
Benefit Maximum ¹	All covered infertility services and prescription drugs are applied towards a \$15,000 infertility treatment lifetime maximum.	

¹ All maximums apply to the combination of in- and out-of-network benefits.

² In-network copays do not count toward out-of-pocket maximum.

³ Mental health coinsurance does not count towards out-of-pocket maximum.

⁴ Mail Order Prescription drug coverage is *only* available through the Medco Mail Order Drug Program.

⁵ Mother and baby must *each* meet deductible.

If Your Doctor Leaves the Network

Because your employee contributions are made on a pre-tax basis, the Internal Revenue Code requires that your election remain in effect through the end of the tax year. If your primary care physician decides to leave the network, you can continue to be treated by him or her and utilize the out-of-network benefits. If you wish to utilize in-network benefits, you will need to change to an in-network physician. You will not be permitted to cancel your Medical Plan enrollment until the next Open Enrollment period, with the cancellation being effective the following January 1st.

Reasonable and Customary Charges

Out-of-network benefits are reimbursed at 70% of “reasonable and customary” expenses. The reasonable and customary charge for a service or supply is the lower of:

- The provider’s usual charge for furnishing it; or
- The charge Aetna determines to be the prevailing charge level made for that service or supply in the geographic area where it is furnished.

In determining the reasonable and customary charge for a service or supply that is unusual or not often provided in your area, or provided by only a small number of providers in your area, Aetna may take into account factors such as: complexity of the procedure, degree of skill needed, type of specialty of the provider, range of services or supplies provided by a facility and the prevailing charge in other areas.

Example of Reasonable and Customary Limit

- Your out-of-network physician charges \$300 for a specific procedure.
- If Aetna determines that the reasonable and customary limit for that procedure is \$200.
- The difference (\$100) is not a covered expense under the Plan; it is not reimbursable and does not count toward your deductible or out-of-pocket maximum.
- The reasonable and customary portion of the expense (\$200) is a covered out-of-network expense, reimbursable at 70% (\$140) after you have met your calendar year deductible.

Pretreatment Review

You or your doctor should contact Aetna before any major out-of-network treatment begins to determine the reasonable and customary charge for that procedure. Contact Member Services at (800) 345-4432 to obtain a “pretreatment estimate” for any procedure.

Medical Necessity

In order for an expense to be covered, it must be determined by Aetna to be medically necessary. A service or supply furnished by a particular provider is deemed medically necessary if Aetna determines that it is appropriate for the diagnosis, the care or the treatment of the disease or the injury involved.

To be considered appropriate, the service or supply must be:

- Care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative care or treatment, both as to the disease or injury involved and the person's overall health condition; or
- A diagnostic procedure, indicated by the health status of the person, as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative diagnostic procedure, both as to the disease or injury involved and the person's overall health condition.

In addition, the service or supply must cost no more (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining whether a service or supply is appropriate under the circumstances, Aetna will take into consideration information provided on the affected person's health status, reports in peer-reviewed medical literature, reports and guidelines published by nationally recognized health care organizations that include supporting scientific data, generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment, the opinion of health professionals in the generally recognized health specialty involved and any other relevant information brought to Aetna's attention.

In no event will the following services or supplies be considered to be medically necessary:

- Those that do not require the technical skills of a medical, mental health or dental professional.
- Those furnished mainly for the personal comfort or convenience of the patient, any person who cares for the patient, any person who is part of the patient's family, or any health care provider or health care facility.
- Those furnished solely because the person is an in-patient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined.
- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

Maximum Lifetime Benefits

There is no lifetime maximum under the Lehman Brothers Medical Plan except that associated with infertility treatment benefits.

Aetna Member Services

Member Services at Aetna consists of a team of professionals who are available to provide network information and answer any questions you may have about your coverage.

You can reach Member Services by calling (800) 345-4432 from 8:00 a.m. to 6:00 p.m., Monday through Friday, Eastern Standard Time.

Call Member Services to:

- Obtain information about network providers in your area (e.g., availability, location, office hours);
- Register comments about network providers;

- Find out about network facilities and services; and
- Ask questions about plan features and procedures.

Coverage While Traveling

If you or your covered dependents need medical care while traveling on a vacation or business trip outside the network area, the Plan will provide coverage as follows:

- If you have a medical emergency¹, get treatment immediately. Then notify Aetna within 48 hours.
- If you have a minor illness (e.g., cold or flu), you can call Aetna for a referral to an in-network physician in the area.

Coordination of Benefits with Other Group Medical Plans

Some persons have health coverage in addition to coverage under this Plan. Under these circumstances, it is not intended that a plan provide duplicate benefits (see the Non-Duplication of Benefits section). For this reason, many plans, including this Plan, have a “coordination of benefits” provision.

Under the coordination of benefits provision of this Plan, the amount normally reimbursed under this Plan is reduced to take into account payments made by “other plans”.

When this and another health expenses coverage plan applies, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.
2. A plan which covers a person as the primary enrollee (e.g. as an employee) will be deemed to pay its benefits before a plan which covers the person as a dependent. However, if the person is also a Medicare beneficiary as a result of the Social Security Act of 1965, as amended:
 - If the covered individual is a U.S. benefits-eligible employee who is still actively at work (e.g. not on long term disability or COBRA) or a dependent of such an individual, Medicare will be considered secondary to the Lehman Brothers Medical Plan.
 - If the covered individual is not a U.S. benefits-eligible employee who is still actively at work (e.g. on long term disability, COBRA or a retiree) or a dependent of such an individual, Medicare will be considered primary to the Lehman Brothers Medical Plan.

The only exception to the above Medicare rule is that once a covered person has had end stage renal disease (ESRD) for 33 months Medicare will be considered primary to the Lehman Brothers Medical Plan until 36 months following a successful kidney transplant operation, even if they are still actively at work (or a dependent of an employee that is actively at work).

3. Except in the case of a dependent child whose parents are divorced or separated; if a dependent child is covered under multiple plans, the plan of the parent whose birthday comes first in a calendar year will be primary. For example, if the father was born on August 1st and the mother was born on July 1st, the mother’s plan will be primary, even if the father is older than the mother. If both parents have the same birthday, the primary plan will be determined by which parent has had coverage under their

¹ For the definition of medical emergency, see the Emergency Care section.

plan for a longer period of time. For example, if the father has been covered under his plan for 5 years and the mother has been covered under her plan for 3 years, the father's plan will be considered primary.

If the other plan does not have a rule similar to the one described in this provision (3), but instead it has a rule based on the gender or age of the parent, the rule of the other plan will determine the order of benefits.

4. In the case of a dependent child whose parents are divorced or separated:
 - a. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in provision (3) will apply.
 - b. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, that parent's plan will be considered primary.
 - c. If there is no such court decree:
 - If the parent with custody of the child has not remarried, that parents' plan will be considered primary and the plan of the parent without custody will be considered secondary..
 - If the parent with custody of the child has remarried, that parent's plan will be considered primary, their spouse's plan will be considered secondary and the plan of the parent without custody will be considered tertiary.
5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

The benefits of a plan which covers a primary enrollee who is a:

- laid-off or retired employee; or
- the dependent of such person;

shall be determined after the benefits of any other plan which covers such person as:

- an employee who is not laid-off or retired; or
- a dependent of such person.

If the other plan does not have a provision regarding laid-off or retired employees and as a result, the plans disagree on which plan should be primary, then the above paragraph will not apply.

The benefits of a plan which covers the person under a right of continuation of benefits pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation. If the other plan does not have a provision regarding right of continuation pursuant to federal or state law and as a result, the plans disagree on which plan should be primary, then this paragraph will not apply.

The general rule is that the benefits otherwise payable under this Plan for all expenses incurred in a calendar year will be reduced by all "other plan" benefits payable for those expenses. When the coordination of benefits rules of this Plan and an "other plan" both agree that this Plan is primary, the benefits of the other plan will be ignored determining the amount that will be reimbursed.

Aetna may release or obtain data in order to administer this provision or to make or recover payments.

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limits of this Plan.

Definition of “Other Plan”

The term “other plan” means any other plan of health expense coverage under:

- Group insurance.
- Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
- No-fault auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.

Non-Duplication of Benefits

If your spouse and/or dependents are covered by another group medical plan, full in-network benefits are only available if coverage under the Lehman Brothers Medical Plan is primary. In-network benefits may be available for certain services (such as preventive care) that are not covered under the primary plan. Please call Member Services at 800-345-4432 to verify what might be covered under the Lehman Brothers Medical Plan as secondary coverage.

Out-of-Network benefits are available as secondary coverage in accordance with the Lehman Brothers Medical Plan’s “non-duplication of benefits” provision. The non-duplication of benefits provision applies if you or a covered dependent are eligible to receive benefits from more than one group medical plan. Benefits paid under any other group medical plan or under a no-fault insurance policy will be deducted from the out-of-network benefits the Lehman Brothers Medical Plan would otherwise pay, and this Plan will pay the difference, but only up to the amount that would have been paid as out-of-network benefits under the Lehman Brothers Medical Plan. If payment received from the other plan is equal to or greater than the amount of out-of-network benefits the Lehman Brothers Medical Plan would have paid, you will not receive payment under this Plan.

For example: Assume you work for Lehman Brothers and your spouse works for another company and both of you have coverage through your respective employers’ plans. Your spouse visits a doctor who is not in the Aetna network and incurs covered expenses of \$100. Your spouse then receives \$80 from his or her medical plan. Assuming your spouse’s deductible had already been met, the Lehman Brothers Medical Plan would not pay the \$20 balance, because \$70 is the maximum out-of-network benefit the Lehman Brothers Medical Plan would have paid.

If your spouse’s deductible has not been met, and is greater than your out-of-network deductible, then the Lehman Brothers Medical Plan will recognize as an out-of-network covered expense any amount in excess of this Plan’s deductible, provided the expenses were credited against the deductible of your spouse’s plan and are reasonable and customary (see the “Reasonable and Customary Charges” section for details).

Physicians

Primary Care Physicians

Although you are not required to designate a primary care physician under the Lehman Brothers Medical Plan, it is recommended that you consult one for most of your medical needs. Internists, general practitioners, family practitioners and pediatricians are considered primary care physicians. The following are tips on choosing an in-network primary care physician:

- Find out if your current doctor is in the Aetna network by checking your provider directory or by calling the physician's office.
- Decide what type of physician you want for yourself and each of your covered dependents (i.e., internist, family practitioner, general practitioner or pediatrician).
- Using the provider directory, make a list of all the doctors in each category who appeal to you. Consider the following criteria:
 - Is the doctor located close to your home or office (whichever is more convenient for you)?
 - Is the doctor affiliated with the network hospital you prefer to use?
 - Ask people you know if they have had experience with any of the doctors on your list. You can also call your current physician for a recommendation.
- Call or visit the office and talk with the doctor's staff. Find out about office hours, emergency procedures, how long you have to wait for an appointment, medical services available when the doctor is out of town, and other issues that matter to you.

In-Network Benefits

Services received from an in-network primary care physician are 100% covered for preventative and wellness care. Other services from an in-network primary care physician are covered at 100% after a \$20 copay. Services received from an in-network lab or facility, all tests and laboratory fees are covered by the Plan at 100% with no copay. In-hospital doctors' visits and services are covered at 90% of the negotiated network cost.

Out-of-Network Benefits

If you choose to consult a non-network primary care physician, covered expenses will be reimbursed under the out-of-network provision: after you meet your annual deductible, the Plan reimburses at 70% of reasonable and customary charges.

Specialists

The Aetna network is composed of specialists in all medical fields who have agreed to provide services for Plan participants.

In-Network Benefits

You do not need a referral from a primary care physician in order to be eligible for in-network benefits. Services received from an in-network specialist are 100% covered for preventative and wellness care. Other services from an in-network specialist are covered at 100% after a \$20 copay. Services received from an in-network lab or facility, all tests and laboratory fees are covered by the Plan at 100% with no copay. In-hospital doctors' visits and services are covered at 90% of the negotiated network cost.

Out-of-Network Benefits

If you choose to consult a non-network specialist, covered expenses will be reimbursed under the out-of-network provision: after you meet your annual deductible, the Plan reimburses at 70% of reasonable and customary charges.

Precertification of Hospital Stays and Outpatient Procedures

You or your physician must call Aetna in advance to “precertify” the following:

- All non-emergency hospital admissions,
- Treatment in skilled nursing home facilities,
- Care from home health care agencies and hospices, and
- Outpatient surgical procedures performed at a hospital or surgical center

Certification of days can be obtained as follows:

If the admission is a non-urgent admission, you must get the days certified by calling the number shown on your ID card. This must be done at least 14 days before the date the person is scheduled to be confined as a full-time inpatient. If the admission is an emergency admission or an urgent admission, you, the person’s physician, or the hospital must get the days certified by calling the number shown on your ID card. This must be done:

- before the start of a confinement as a full-time inpatient which requires an urgent admission; or
- not later than 48 hours following the start of a confinement as a full-time inpatient which requires an emergency admission; unless it is not possible for the physician to request certification within that time. In that case, it must be done as soon as reasonably possible. (In the event the confinement starts on a Friday or Saturday, the 48 hour requirement will be extended to 72 hours.)

If, in the opinion of the physician, it is necessary to be confined for a longer time than already certified, you, the physician or the hospital may request that more days be certified by calling the number shown on your ID card. This must be done no later than on the last day that has already been certified.

Written notice of the number of days certified will be sent promptly to the hospital. A copy will be sent to you and to the physician.

If you or your covered dependent becomes confined in a hospital as a full-time patient and Aetna has not certified that such hospitalization is necessary and the hospitalization has not been ordered and prescribed by a physician, covered medical expenses incurred on any day not certified will be paid as follows:

For Hospital Expenses incurred during the confinement:

- If certification has been requested and denied:
 - No benefits will be paid for Hospital Expenses incurred for board and room.
 - Benefits for all other Hospital Expenses will be paid in accordance with the Plan benefits.
- If certification has not been requested and the confinement (or any day of such confinement) is not necessary:
 - No benefits will be paid for Hospital Expenses incurred for board and room.
 - As to all other Hospital Expenses:
 - Expenses, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.
 - Benefits for such expenses in excess of the Excluded Amount will be paid in accordance with Plan benefits.

- If certification has not been requested and the confinement (or any day of such confinement) is necessary:
 - Hospital Expenses incurred for board and room, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.
 - Benefits for all other Hospital Expenses will be payable in accordance with Plan benefits.
 - As to other Covered Medical Expenses:
 - Benefits will be paid in accordance with Plan benefits.

Whether or not a day of confinement is certified, no benefit will be paid for expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this Plan; except that, if certification has been given for a day of confinement, the exclusion of services and supplies because they are not necessary will not be applied to expenses for hospital room and board.

In-Network Benefits

Your in-network physician (primary care physician or specialist) will arrange all necessary precertification for in-network benefits.

Out-of-Network Benefits

Ultimately, you and your doctor decide what treatment you will receive. The Plan determines the level of benefit reimbursement.

Covered Expenses/Plan Benefits

This Summary Plan Description contains general, summarized descriptions of benefits available under the Lehman Brothers Medical Plan. A partial list of expenses not covered under the Lehman Brothers Medical Plan can be found in the Expenses Not Covered section. Copies of the underlying Plan document, with schedules of benefits and exclusions, are available at no charge from the HR Service Center.

Preventive Care/Wellness Benefits

The Medical Plan provides for preventive care benefits on both an in- and out-of-network basis.

Routine Physicals

The Lehman Brothers Medical Plan provides for routine physical examinations, regardless of whether you have been ill or injured, according to the following schedule:

In-Network: The Plan covers 100%.

Out-of-Network: The Plan will reimburse 70% of reasonable and customary charges after you have met your calendar year deductible.

Well-Baby and Well-Child Care

Under the Lehman Brothers Medical Plan, your dependent children are covered for all well-baby and well-child visits.

In-Network: The Plan covers 100%.

Out-of-Network: The Plan will reimburse 70% of reasonable and customary charges after you have met your calendar year deductible.

Routine Gynecological Examinations

In addition to the routine physicals described above, the Medical Plan covers all routine gynecological exams.

In-Network: The Plan covers 100%.

Out-of-Network: The Plan will reimburse 70% of reasonable and customary charges after you have met your calendar year deductible.

Routine Mammography

In addition to medically necessary mammography, the Lehman Brothers Medical Plan covers all routine mammograms.

In-Network: The Plan covers 100%.

Out-of-Network: The Plan will reimburse 70% of reasonable and customary charges after you have met your calendar year deductible.

Routine Male Cancer Screening

In addition to medically necessary cancer screening, men age 40 and older are covered for routine digital rectal exams and laboratory fees for Prostate Specific Antigen.

In-Network: The Plan covers 100%

Out-of-Network: The Plan will reimburse 70% of reasonable and customary charges after you have met your calendar year deductible.

Routine Eye Exam

Covered Medical Expenses include charges for a complete eye exam, including refraction, which is furnished by a legally qualified ophthalmologist or optometrist to a person.

The following types of eye exams are not covered under the Plan:

- an eye exam, or any part of an eye exam, performed for the purpose of the fitting of contact lenses;
- drugs or medicines;
- any services or supplies which are included as covered expenses under any other benefit section included in this Plan or under any other plan of group benefits provided through the Firm (such as the Lehman Brothers Vision Care Plan);
- any service or supply which does not meet professionally accepted standards;
- any exams given while the person is confined in a hospital or other facility for medical care

In-Network. The Plan covers 100%.

Out-of-Network. The Plan will reimburse 70% of reasonable and customary charges after you have met your calendar year deductible.

Routine Hearing Exam

Covered Medical Expenses include charges for an audiometric exam.

The services must be performed by a physician certified as an otolaryngologist or otologist or an audiologist who either is legally qualified in audiology; or holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any applicable licensing requirements; and who performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

The following types of hearing exams are not covered under the Plan:

- drugs or medicines;
- any hearing care service or supply which is a covered expense in whole or in part under any other part of this Plan or under any other plan of group benefits provided through your Employer;
- any hearing care service or supply which does not meet professionally accepted standards;
- any exams given while the person is confined in a hospital or other facility for medical care.

In-Network. The Plan covers 100%

Out-of-Network. The Plan will reimburse 70% of reasonable and customary charges after you have met your calendar year deductible.

Routine Foot Care

Services of a podiatrist are covered for the treatment of a disease or injury, including but not limited to treatment of corns, calluses, keratoses, bunions, and ingrown nails. Aetna does not consider pedicure services, such as routine cutting of nails, in the absence of disease of nails, as medically necessary treatment of disease.

In-Network. The Plan covers 100% after a \$30 copay.

Out-of-Network: The Plan will reimburse 70% of reasonable and customary charges after you have met your calendar year deductible.

Simple Steps To A Healthier Life

Simple Steps To A Healthier Life[®] is an interactive online health and wellness program that can help you improve or maintain your health in ways that fit your lifestyle. The program takes you step-by-step to help you achieve your health goals. You and your eligible family members will be able to identify some of your health needs, receive a tailored Health Report and a personalized Action Plan, and participate in recommended Healthy Living Programs. More information is available at www.simplestepslife.com or on Aetna Navigator at www.aetna.com under the section marked 'Take Action on Your Health.'

MedQuery

The MedQuerySM program identifies opportunities for improved care and delivers specific, evidence-based treatment guidelines to physicians.

The program applies over 700 clinical algorithms to identify potential errors, omissions or commissions in your care and the care provided to your eligible family members. The specific opportunities are then communicated to your treating physician according to evidence-based medical research. After your physician is notified, you will also receive a letter, called a 'Care Consideration' advising you of this opportunity for improved care and avoidance of adverse health events.

As medical care becomes more and more complex, and patients are treated by an increasing number of highly specialized physicians, the use of computerized systems to identify opportunities to improve care and prevent error become ever more important.

While all treatment decisions are ultimately the responsibility of the physician in consultation with you, their patient, MedQuery serves as a valuable resource in prompting a doctor to consider aspects of your care that they might otherwise have overlooked.

Aetna Health Connections (for Nebraska Members)

Lehman Brothers, in conjunction with your medical plan, and Aetna are dedicated to improving your knowledge of and control over your own health care. With this in mind, we are pleased to announce an expanded, called Informed Care Management (ICM).

Aetna Health Connections is a free, voluntary program offered through Aetna to provide you and your eligible family members with personalized information about your health. For specific health conditions, you will have the opportunity to work one on one with a Nurse Care Manager who acts as your "personal health coach". The program has been proven to help many people with specific health conditions, like asthma or diabetes, to better manage their health and take active steps to work with their doctors to improve their care. Your health information and participation in this program is confidential.

Your Nurse Care Manager or "personal health coach" will:

- Help you better understand your health condition
- Review your health information with you and prepare a list of questions for you to ask your doctor
- Identify ways for you to take control of your health
- Provide you with information about treatment options, which you can discuss with your doctor

If you are contacted by Nurse Care Manager, we strongly encourage you to take advantage of the program.

Benefits for Medical Illness or Injury

The Lehman Brothers Medical Plan provides coverage for medical illness and injury under both in-network and out-of-network benefits.

In-Network

If you (or a covered dependent) become ill or are injured, contact your primary care physician for an office visit. If you require the services of a specialist, your primary care physician can refer you to an in-network specialist or you may select any in-network specialist from the Aetna provider directory. The cost to you is \$20 for each office visit to a primary care physician; \$30 for each office visit to a specialist.

Out-of-Network

The Lehman Brothers Medical Plan provides out-of-network coverage for medical illness and injury in much the same way as a typical major medical plan. After you meet your annual deductible, the Plan reimburses 70% of covered expenses until you reach your annual out-of-pocket maximum, after which the Plan reimburses covered expenses at 100%. See the charts for deductible and out-of-pocket maximum amounts.

Only expenses which are deemed medically necessary by Aetna are eligible for reimbursement under the out-of-network benefits. In addition, only that portion of a charge that is determined by Aetna to be reasonable and customary is covered. See the Reasonable and Customary Charges and the Medical Necessity sections for details.

Hospital Expenses

Expenses for the following are covered under the Lehman Brothers Medical Plan when they are provided for medical illness or injury:

- Hospital room and board in a semiprivate room.
- Operating room, recovery room and equipment.
- Drugs, medications and dressings.
- Oxygen.
- Intensive care.
- Laboratory tests.
- Emergency room treatment (see the Emergency Care section for details).

All non-emergency hospitalizations must be precertified, and all emergency hospitalizations must be certified by Aetna. See the Precertification of Hospital Stays and Out-Patient Procedures section for details.

In-Network

In-network hospital expenses are covered at 90% of the negotiated network cost until you have met your in-network calendar year out-of-pocket maximum. Thereafter, coverage is provided at 100% of the negotiated network cost.

Out-of-Network

Out-of-network hospital costs are covered at 70% of reasonable and customary charges, after you have met your calendar year deductible. Once you reach your out-of-network calendar year out-of-pocket maximum, coverage is provided at 100% of reasonable and customary charges.

Treatment by an Urgent Care Provider

You should not seek medical care or treatment from an Urgent Care Provider if your illness; injury; or condition; is an emergency condition. Please go directly to the emergency room of a hospital or call 911 (or the local equivalent) for ambulance and medical assistance.

Urgent Care

This Plan pays for the charges made by an Urgent Care Provider to evaluate and treat an urgent condition.

When travel to an Urgent Care Provider for treatment of an urgent condition is not feasible, such treatment may be paid at the in-network level of benefits. If a claim for treatment of an urgent condition is paid at the out-of-network level and you believe that it should have been paid at the in-network level, please contact Members Services at the toll-free number on your I.D. card.

Non-Urgent Care

Covered Medical Expenses for charges made by an Urgent Care Provider to treat a non-urgent condition will be paid on the same basis as those made by an out-of-network Urgent Care Provider .

Non-urgent care includes, but is not limited to, the following:

- routine or preventive care (this includes immunizations);
- follow-up care;
- physical therapy;
- elective surgical procedures; and
- any lab and radiologic exams which are not related to the treatment of the urgent condition.

Outpatient Surgical Expenses

Covered Medical Expenses include charges for outpatient surgical expenses to the extent shown below. Covered Medical Expenses include charges made:

- on its own behalf by:
 - a surgery center;
 - the outpatient department of a hospital; or
 - an office based surgical facility of a physician or a dentist.
- by a physician;
- on behalf of a salaried staff physician by the outpatient department of a hospital.

For Outpatient Services and Supplies furnished in connection with a surgical procedure performed in the center or in a hospital, the procedure must meet these tests:

- It is not expected to:
 - result in extensive blood loss;
 - require major or prolonged invasion of a body cavity; or
 - involve any major blood vessels.
- It can only be performed safely and adequately in a surgical center, in a hospital, or in an office based surgical facility of a physician or a dentist.
- It is not normally performed in the office of a physician or a dentist.

Outpatient Services and Supplies are:

- Services and supplies furnished by the surgery center or by a hospital on the day of the procedure.
- Services of the operating physician for performing the procedure and for:
 - related pre and postoperative care; and
 - the administering of an anesthetic.
- Services of any other physician for related postoperative care and for the administering of an anesthetic. This does not include a local anesthetic.

Limitations:

No benefit is paid for charges incurred:

- For the services of a physician who renders technical assistance to the operating physician.
- While the person is confined as a full-time inpatient in a hospital.

Multiple Surgery or Bilateral Procedures

In-Network

For procedures performed by an in-network provider, the first procedure is paid at 100%, the second or opposite side procedure at 50%, and any subsequent procedures at 25%. In-network providers accept Aetna negotiated rates and may not balance bill you. In-network deductible and coinsurance applies.

Out-of-Network

Multiple Surgeries. When an out-of-network surgeon performs more than one eligible procedure on the same patient during the same operative session, Aetna calculates the allowable benefit as follows:

- 100% of reasonable and customary rates for the first procedure. Out-of-network deductible and coinsurance applies.
- 50% of reasonable and customary rates the second procedure. Out-of-network deductible and coinsurance applies.
- 25% of reasonable and customary rates for each subsequent procedure. Out-of-network deductible and coinsurance applies.

Bilateral Procedures. A surgical procedure is considered bilateral when the same procedure is performed on both sides of the body. Common anatomical sites for bilateral surgical procedures are

extremities, eyes, ears, and breasts. When a surgeon performs bilateral surgery, or a combination of both bilateral and multiple surgery, Aetna calculates the allowable benefit for the eligible procedures in the same manner as for multiple surgery:

- 100% of reasonable and customary rates for the first procedure. Out-of-network deductible and coinsurance applies.
- 50% of reasonable and customary rates the second procedure. Out-of-network deductible and coinsurance applies.
- 25% of reasonable and customary rates for each subsequent procedure. Out-of-network deductible and coinsurance applies.

Incidental surgeries are not reimbursed if billed separately (a procedure that is performed at the same time as a primary procedure, which requires little additional physician resources and/or is clinically and integral part of the performance of the primary procedure).

Gastric Bypass Surgery

In order to qualify for coverage of gastric bypass surgery, you must provide documentation demonstrating that morbid obesity has persisted for 5 years or more and that physician-supervised diet and exercise programs have not been effective.

Morbid obesity is defined as a body mass index (BMI) of 40 or higher; or a BMI of 35 or higher with other medical conditions such as heart disease, diabetes, obstructive sleep apnea and/or hypertension (blood pressure greater than 140 systolic or 90 diastolic).

In addition to documentation regarding morbid obesity, you will need to provide documentation of either A or B below. Note: A physician's summary letter, without evidence of oversight, is not sufficient documentation for criteria A or B.

- A. Nutrition and exercise program, with behavioral modification, with all of the following:
- a. Physician-supervised with dietitian consultation; and
 - b. Of 6 months duration, with at least 3 months consecutive; and
 - c. Within 2 years of surgery; and
 - d. Documented in the medical record by the physician supervising participation.

OR

- B. Multidisciplinary pre-surgical regimen for at least 3 months with all of the following:
- a. Documentation in the medical record, including physician's initial assessment and progress at completion; and
 - b. Diet program including nutritionist supervision; and
 - c. Exercise regimen (unless contraindicated) to improve pulmonary reserve, supervised by a qualified professional; and
 - d. Behavior modification supervised by a qualified professional.

Skilled Nursing Facility (Convalescing)

Charges for inpatient convalescent care in a skilled nursing facility are covered for a maximum of 120 days per calendar year. All skilled nursing facility care must be pre-certified by Aetna. See the Precertification of Hospital Stays and Out-Patient Procedures section for details.

Covered charges include the following:

- Board and room. This includes charges for services, such as general nursing care, made in connection with room occupancy. Not included is any charge for daily board and room in a private room over the Private Room Limit.
- Use of special treatment rooms.
- X-ray and lab work.
- Physical, occupational or speech therapy.
- Oxygen and other gas therapy.
- Other medical services usually given by a convalescent facility. This does not include private or special nursing, or physician's services.
- Medical Supplies.

Benefits will be paid for no longer than 120 days during any one calendar year.

Not included are charges made for the treatment of:

- Drug addiction.
- Chronic brain syndrome.
- Alcoholism.
- Senility.
- Mental retardation.
- Any other mental disorder.

In-Network

The Plan covers 90% of the negotiated network cost for a semi-private room until you have met your in-network calendar year out-of-pocket maximum. Thereafter, the Plan covers 100% of the negotiated network cost.

Out-of-Network

The Plan will reimburse 70% of reasonable and customary charges for a semi-private room after you have met your calendar year deductible. Once you have met your out-of-network calendar year out-of-pocket maximum, the Plan will reimburse 100% of reasonable and customary charges.

Skilled Nursing Care Expenses

The charges made by a R.N. or L.P.N. or a nursing agency for "skilled nursing services" are included as Covered Medical Expenses. No other charges made by a R.N. or L.P.N. or a nursing agency are covered. As used here, "skilled nursing services" means these services:

- Visiting nursing care by a R.N. or L.P.N. Visiting nursing care means a visit of not more than 4 hours for the purpose of performing specific skilled nursing tasks.
- Private duty nursing by a R. N. or L.P.N. if the person's condition requires skilled nursing care and visiting nursing care is not adequate.

Benefits will not be paid during a calendar year for private duty nursing for any shifts in excess of 70 shifts per calendar year. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.

Not included as "skilled nursing services" is:

- that part or all of any nursing care that does not require the education, training and technical skills of a R.N. or L.P.N.; such as transportation, meal preparation, charting of vital signs and companionship activities; or
- any private duty nursing care, given while the person is an inpatient in a hospital or other health care facility; or
- care provided to help a person in the activities of daily life; such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting; or
- care provided solely for skilled observation except as follows:
 - for no more than one 4 hour period per day for a period of no more than 10 consecutive days following the occurrence of:
 - change in patient medication;
 - need for treatment of an emergency condition by a physician, or the onset of symptoms indicating the likely need for such services;
 - surgery; or
 - release from inpatient confinement; or
- any service provided solely to administer oral medicines; except where applicable law requires that such medicines be administered by a R.N. or L.P.N.

Home Health Care Expenses

Home health care expenses are covered if:

- the charge is made by a home health care agency; and
- the care is given under a home health care plan; and
- the care is given to a person in his or her home.

Home health care expenses are charges for:

- Part-time or intermittent care by an R.N. or by an L.P.N. if an R.N. is not available.
- Part-time or intermittent home health aide services for patient care.
- Physical, occupational, and speech therapy.
- The following to the extent they would have been covered under this Plan if the person had been confined in a hospital or convalescent facility:
 - medical supplies;
 - drugs and medicines prescribed by a physician; and
 - lab services provided by or for a home health care agency.

The following charges are not covered:

- Services or supplies that are not a part of the home health care plan.
- Services of a person who usually lives with you or who is a member of your or spouse/domestic partner's family.
- Services of a social worker.
- Transportation.

Home health care is covered at 90% of the negotiated network cost.

Out-of-network home health care is covered at 70% of reasonable and customary charges after you have met your calendar year deductible.

Hospice Care

Charges made for the services furnished to a person for Hospice Care when given as a part of a Hospice Care Program are included as Covered Medical Expenses.

These covered services include charges made by a hospice facility, hospital, or convalescent facility for inpatient care including:

- Board and room
- other services and supplies furnished while a full-time inpatient for:
 - pain control; and
 - other acute and chronic symptom management.

Any charge for daily board and room in a private room over the Private Room Limit is not covered under the Plan. In addition, any day of confinement in excess of the 60 day Hospice Care maximum is not covered under the Plan.

Covered charges made by a Hospice Care Agency for services and supplies furnished to a person on an out-patient basis are as follows:

- Part-time or intermittent nursing care by an R.N. or L.P.N. for up to 8 hours in any one day.
- Medical social services under the direction of a physician. These include:
 - assessment of the person's:
 - social, emotional, and medical needs; and
 - the home and family situation;
 - identification of the community resources which are available to the person; and
 - assisting the person to obtain those resources needed to meet the person's assessed needs.
- Psychological and dietary counseling.
- Bereavement counseling.
- Consultation or case management services by a physician.
- Physical and occupational therapy.
- Part-time or intermittent home health aide services for up to 8 hours in any one day. These consist mainly of caring for the person.
- Medical supplies.
- Drugs and medicines prescribed by a physician.
- The following charges made by a provider of Outpatient Care are only covered if the provider is not an employee of a Hospice Care Agency that retains responsibility for the care of the patient.
- A physician for consultant or case management services.
- A physical or occupational therapist.
- A Home Health Care Agency for:
 - physical and occupational therapy;
 - part-time or intermittent home health aide services for up to 8 hours in any one day; these consist mainly of caring for the person;
 - medical supplies;
 - drugs and medicines prescribed by a physician; and
 - psychological and dietary counseling.

The Hospice Outpatient Maximum of \$25,000 will apply to all Hospice Care Expenses incurred; including inpatient care expenses and expenses incurred while the person is not confined as a full-time inpatient.

Covered expenses under the Hospice Care provisions of the Plan do not include:

- Funeral arrangements.
- Pastoral counseling.
- Financial or legal counseling; including estate planning and the drafting of a will.
- Homemaker or caretaker services. (These are services which are not solely related to care of the person; including sitter or companion services for either the person who is ill or other members of the family; transportation; housecleaning; and maintenance of the house.)
- Respite care. (This is care furnished during a period of time when the person's family or usual caretaker cannot, or will not, attend to the person's needs.)

In-Network

Hospice care is covered at 90% of the negotiated network cost.

Out-of-Network

Hospice care is covered at 70% of reasonable and customary charges after you have met your calendar year deductible.

Medical Services and Supplies

Expenses for the following are covered under the Lehman Brothers Medical Plan when they are provided for medical illness or injury:

- Physicians' fees for home or office visits.
- Consultation charges made by your attending physician or specialist.
- Operations and other surgical procedures on an in-patient basis, or as an out-patient at a hospital (or other licensed medical facility), or in your doctor's office.
- Administration of anesthesia.
- X-ray treatment by a radiologist.
- Lab tests to diagnose or treat your condition.
- Professional ambulance service to and from the nearest hospital where treatment can be rendered. Both the ambulance service and the medical treatment must be "medically necessary."
- Pre-admission testing performed before admission to the hospital.
- Surgical procedures performed in an independent ambulatory surgical facility (sometimes called a short procedure unit or surgicenter).
- Second surgical opinions.
- Home health care.
- Acupuncture performed by a state-licensed Medical Doctor or acupuncturist certified by the American Association for Acupuncture and Oriental Medicine who is practicing within the laws of the jurisdiction where treatment is given.

Benefits are paid at either in-network or out-of-network levels according to provider's participation in the Aetna Choice POS II network..

Emergency Care

A “medical emergency” is a sudden and unexpected change in a person’s physical or mental condition that is severe enough to require immediate hospital-level care. Examples include unconsciousness, severe difficulty breathing, poisoning, heart attack and serious bleeding. If you are unsure whether a situation qualifies as an “emergency” as defined above, call your primary care physician first. (All network doctors are required to provide 24-hour telephone coverage.) *Use of an emergency room for a non-emergency is not covered under the Plan; you will be responsible for the entire charge.*

Emergency care is considered an in-network expense, regardless of the hospital’s affiliation. Your cost for the treatment will be a 10% of reasonable and customary expenses, whether the hospital is in- or out-of-network.

Penalty for Not Certifying Emergency Admission

If you do not contact Aetna to certify an emergency admission within 48 hours from the time you are admitted to the hospital, you may be required to pay an additional \$400 under the Hospital Precertification clause of this Plan, as described in the Precertification of Hospital Stays and Out-Patient Procedures section.

Gynecological Care

A female participant in the Lehman Brothers Medical Plan (employee, spouse or dependent) may contact any network obstetrician/gynecologist to obtain the following covered services:

- Routine gynecological exams.
- Any necessary follow-up care.
- Acute or long-term gynecological care services.
- Services related to pregnancy.
- Necessary hospitalization.

Covered procedures include tubal ligation and abortion.

Reconstructive Surgery Following Mastectomy

When a covered individual receives benefits for a mastectomy and decides to have breast reconstruction, based on consultation between the attending physician and the patient, the Plan will cover:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance; and
- Prostheses and physical complications in all stages of mastectomy including lymphedema.

Maternity

In addition to the following medical benefits, employees (or their spouses) enrolled in the Lehman Brothers Medical Plan are entitled to participate in a prenatal program. See the Moms to Babies Prenatal Program section below for details about the program and information on how to register.

You may change your coverage level under the plan (e.g. from individual plus one to family coverage) within 31 days after your baby(ies) is(are) born. See the Mid-Year Changes to Coverage section for details. **However, even if you already have family coverage under the plan you must contact the HR Service Center to enroll your baby(ies) in the plan within 31 days of your baby(ies) birth.**

In-Network Maternity Benefits

The Lehman Brothers Medical Plan provides the following in-network maternity benefits:

For the mother: You may choose any network obstetrician. You will pay one \$30 copay for the first prenatal office visit to your network obstetrician. Subsequent prenatal obstetric visits with the same physician for the same pregnancy are covered at 100%. Your cost for your (or your spouse's) hospital stay will be 90% of the negotiated network cost.

For the baby: Provided that you elect to cover the newborn(s) under this Plan, your cost for the newborn's(s') hospital services will be 90% of the negotiated network cost (subject to the Coordination of Benefits provisions described in Whose Plan is Primary and Coordination with Other Group Medical Plans).

Out-of-Network Maternity Benefits

If you choose to see an out-of-network obstetrician, you will be reimbursed for 70% of reasonable and customary expenses, after you meet your calendar year deductible, up to your out-of-network calendar year out-of-pocket maximum. (See the charts for deductible and out-of-pocket maximum amounts.) Provided that you elect to cover the newborn(s) under this Plan, charges for the newborn's(s') hospital stay and in-hospital care will also be covered expenses (subject to the Coordination of Benefits provisions described in Whose Plan is Primary and Coordination with Other Group Medical Plans). Both the mother and the baby(ies) will have to meet a deductible, unless your family has already met the maximum Family deductible for the current calendar year.

Maternity Hospital Length of Stay

The hospital length of stay for both the mother and the newborn child will not be restricted to less than 48 hours following vaginal delivery or less than 96 hours following delivery by cesarean section. However, your length of stay may be shorter if your attending provider (i.e. your physician, nurse midwife or physician assistant), after consultation with you, discharges you or your newborn child earlier.

Moms-to-Babies Prenatal Program

The Aetna Moms-to-Babies Maternity Management Program provides women with services, information and resources throughout their pregnancies. The program provides early risk identification, care coordination by obstetrical nurses and support.

You are automatically enrolled in the Moms-to-Babies Maternity Management Program when your obstetrical care providers notify Aetna, generally after the first prenatal care visit. You may also enroll yourself in the program by calling 1-800-CRADLE-1 (1-800-272-3531).

Moms-to-Babies participants have access to the following:

- Women's health obstetrical nurses, who help coordinate your care with participating obstetrical care providers.
- Extensive educational information on prenatal care, labor and delivery, newborn and baby care, postpartum depression, breastfeeding and other pregnancy-related health issues.

- A pregnancy risk survey to help identify potential risk factors and complications.
- Personalized care coordination by experienced obstetrical nurses if the you identify factors that indicate you are high risk.
- Specialized educational information, “For Dad or Partner.”
- Breastfeeding support program.
- A preterm labor and delivery program for women in specific at-risk populations (including those with history of preterm labor). The program includes educational information focusing on the risks of premature labor and delivery, nurse visits and telephone follow-up and outreach.

Members can also participate in Aetna’s Smoke-free Moms-to-be™ smoking cessation program. The program encourages pregnant women who smoke more than five cigarettes per day to quit smoking during pregnancy. The program is nicotine-free and includes an educational booklet that describes the risks associated with smoking during pregnancy, strategies to help you quit smoking, a relaxation audiotape and inspirational video, and an imitation cigarette to be used to satisfy oral needs.

Statement of Rights under the Newborns’ and Mothers Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

Specialized Infant Formulas

Specialized infant formula for children up to age 3 may be covered at 90%, provided they meet the following criteria:

- Formula must be medically necessary specialized oral or enteral dietary formulas required to treat disease or infant metabolic disorders.
- Documentation of medical necessity from an attending physician must be submitted along with the claim.

In general, a specialized infant formula is an oral or enteral dietary formula that is exempt from general requirements of nutritional labeling under the statutory and regulatory guidelines of the Federal Food and Drug Administration. It does not require legal prescription but must be intended for use solely under medical supervision in dietary management of specific diseases.

The Plan does not cover solid-food metabolic products.

Short-Term Rehabilitation - Restorative

Short-term rehabilitation is physical, occupational or speech therapy that is expected to result in the improvement of a body function (including the restoration of the level of an existing speech function) which has been lost or impaired due to an injury or other specific incident such as an accident or illness.

Charges for short-term rehabilitation made by a physician or a licensed or certified physical, occupational or speech therapist for the treatment of acute conditions are covered under the Lehman Brothers Medical Plan, provided the treatment is:

- Furnished to a covered individual who is not confined as an in-patient in a hospital or other facility for medical care; and
- Expected to result in significant improvement of the person's condition within 60 days from the date the therapy begins.

In-network restorative short-term rehabilitation is covered at 100% (after a \$30 copay if a session is billed as an office visit). To be eligible for in-network benefits, you must be referred for short-term rehabilitation by a network physician to a network provider.

Out-of-network benefits for restorative short-term rehabilitation will be reimbursed at 70% of reasonable and customary charges, provided the therapy is deemed medically necessary and effective by Aetna. If Aetna determines that the therapy is not expected to result in significant improvement of your medical condition, reimbursement may be denied.

The Plan will cover up to 60 visits of rehabilitation therapy per calendar year, whether in- or out-of-network. The 60-visit limit applies to any combination of physical, speech and/or occupational therapy.

Restorative Speech Therapy

Speech therapy is a type of short-term rehabilitation. Included under Short-term Rehabilitation, are any charges for speech therapy performed by a physician or licensed, certified speech therapist that is designed to *restore* speech to a patient who has lost the ability to speak due to illness or injury. See Short-term Rehabilitation for details.

Short-Term Rehabilitation – Developmental Delay

Developmental delay disorders are conditions that may result in the absence of or delays in speech development. Developmental delay disorders include but are not limited to autism, Rett syndrome, childhood disintegrative disorder and Asperger's syndrome.

Charges for Short-term Rehabilitation made by a physician or a licensed or certified therapist for the treatment of developmental delay conditions are covered under the Lehman Brothers Medical Plan, provided the treatment is not considered experimental or investigational. The plan administrator considers treatments experimental and investigational when the peer-reviewed medical literature does not support the use of these procedure and services in the assessment and treatment of developmental disorders.

In-network and out-of-network benefits for development delay short-term rehabilitation are covered at 70% of reasonable and customary for up to 30 visits as medically necessary.

Developmental Delays

Speech therapy is a type of short-term rehabilitation. The Plan will cover up to 30 visits of speech therapy performed by a physician, audiologist or speech pathologist on a patient with developmental delays such as autism or PDD. Costs will be reimbursed at 70% of reasonable and customary charges both in- and out-of-network.

Chiropractic Care

The Plan will cover up to 30 visits of chiropractic care per calendar year. The 30-visit limit applies to any combination of in- and out-of-network care.

In-network: If you utilize a chiropractor in the Aetna network, your coverage may vary depending on how your chiropractor bills for his or her services. If your provider bills your session as an office visit, the Plan covers 100% of cost after a \$30 copay per visit. If your session is billed as a physical therapy session, the Plan covers 90% of the negotiated network cost and you are responsible for the remaining 10%.

Out-of-network: After you have met your calendar year deductible, the Plan will reimburse 70% of reasonable and customary charges.

Acupuncture

Covered Medical Expenses include those charges incurred for acupuncture services furnished to a covered family member only if provided by:

- A physician; or
- An acupuncturist certified by the American Association for Acupuncture and Oriental Medicine who is practicing within the laws of the jurisdiction where treatment is given.

Acupuncture services are those which are furnished:

- As a form of anesthesia in connection with surgery that is covered under this policy.
- To treat a non-occupational disease or non-occupational injury.
- To alleviate chronic pain.
- Adult postoperative and chemotherapy-induced nausea and vomiting.
- Nausea of pregnancy.
- Postoperative dental pain.
- Fibromyalgia and myofascial pain.
- Temporomandibular Disorders (TMD).

The Plan will cover up to 30 visits per calendar year.

In-Network

The Plan covers 100% after a \$30 copay.

Out-of-Network

The Plan will reimburse 70% of reasonable and customary charges after you have met your calendar year deductible.

Durable Medical and Surgical Equipment

Durable medical and surgical equipment is defined as equipment that is prescribed by a physician and is:

- Made to withstand prolonged use;
- Made for, and mainly used in, the treatment of a disease or injury;
- Suited for use in the home;
- Not normally of use to persons who do not have a disease or injury;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Rental of durable medical and surgical equipment (except for the exclusions listed below) that has been prescribed by an in-network physician is covered at 100% of reasonable and customary costs. When prescribed by a non-network physician, rental costs are reimbursable as an out-of-network benefit, at 70% of reasonable and customary costs, after the annual deductible has been met.

The purchase of durable medical and surgical equipment and any accessories needed to operate the equipment is covered only if:

- Long-term use is planned; and
- The equipment cannot be rented, or Aetna determines that it is likely to cost less to buy it than to rent it.

Exclusions

The following durable medical and surgical equipment charges are not covered under the Plan:

- Charges for more than one item of durable medical and surgical equipment for the same or similar purpose.
- Eyeglasses.
- Orthopedic shoes or other devices to support the feet.

Hearing Aid Expenses

This Plan pays for charges for hearing aids for loss of hearing. Benefits will not be paid for more than the Hearing Aid Maximum of \$400 per ear every three years.

Not covered are charges for:

- Evaluations and hearing aids rendered before the person becomes eligible for coverage or after termination of coverage.
- Hearing aid batteries.
- Hearing exams required as a condition of employment.
- Special education for a person whose ability to speak or hear is lost or impaired. This includes lessons in sign language, speaking aids and training in the use of such aids.

Infertility Program

Covered expenses for infertility treatment will be reimbursed at 90% for in-network services and at 70% for out-of-network services. In order to be covered, your infertility treatment plan must be submitted to Aetna for pre-approval (in- or out-of-network). Contact Aetna customer service at 800-345-4432 for information on how to submit a treatment plan.

There is a lifetime maximum of \$15,000 for infertility benefits including prescription drugs under the Lehman Brothers Medical Plan.

Infertility is defined as 12 months of unprotected intercourse without conception. Coverage also applies for any condition for which the treatment of that condition would result in infertility.

Even though not incurred for treatment of a disease or injury, Covered Medical Expenses will include expenses incurred by a covered female for infertility if:

- The procedures are performed while not confined in a hospital or any other facility as an inpatient.
- FSH levels are less than or equal to 19 mIU on day 3 of the menstrual cycle.
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this Plan.

The following infertility services expenses will be Covered Medical Expenses:

- Ovulation induction with ovulatory stimulant drugs, subject to a maximum of 6 courses of treatment in a covered person's lifetime.
- Artificial insemination, subject to a maximum of 6 courses of treatment in a covered person's lifetime.
- Cryopreservation of individual eggs
- Cryopreservation of sperm

A course of treatment is one cycle of treatment that corresponds to one ovulation attempt.

Expenses Not Covered

The Plan will not cover charges for the following:

- Purchase of donor sperm;
- Care of donor egg retrievals or transfers;
- Cryopreservation of individual eggs;
- Storage of cryopreserved sperm, egg or embryo;
- Home ovulation predictor kits; and
- Gestational carrier programs.

Teeth, Mouth and Jaws (Including TMJ)

Dental care is *not* covered under the Lehman Brothers Medical Plan, except for the prompt repair of natural healthy teeth that are accidentally injured while you are covered by this Plan. (Benefits are not available for accidental injury of non-natural teeth and/or dentures.) See the Teeth, Mouth and Jaws section of Expenses Not Covered for further dental care exclusions.

Most services for Temporomandibular Joint Syndrome (TMJ) are not covered under the Lehman Brothers Medical Plan. See the Temporomandibular Joint Syndrome section of Expenses Not Covered for details about TMJ services not covered.

When medically necessary, however, and when appliance therapy alone cannot result in functional improvement, surgery to alter the jaw, jaw joints or bite relationships by a cutting procedure is a covered expense. You should submit a pretreatment review to Aetna before services begin to verify coverage of any benefits for the treatment of TMJ.

Mental Health and/or Substance Abuse

Under the Lehman Brothers Medical Plan, Mental Health and/or Substance Abuse services are covered under separate benefit provisions from other medical services.

In-Network

All in-network Mental Health and Substance Abuse benefits are managed by Aetna Behavioral Health, a division of Aetna specializing in the management of psychiatric care. You or your physician can obtain an in-network referral to a participating provider either for in-patient or out-patient services by calling Aetna Behavioral Health at 800-424-4047. In-network benefits are as follows:

In-patient: 90% of the negotiated network cost.

Out-patient: 100% coverage after a \$30 copay per visit; limited to 50 visits per calendar year.

Out-of-Network

Out-of-network Mental Health and Substance Abuse benefits are as follows:

In-patient: Reimbursed at 70% of reasonable and customary charges, after you meet your deductible; all out-of-network hospitalizations must be precertified by Aetna Behavioral Health.

Out-patient: Treatment by a psychiatrist, psychologist or licensed medical social worker is reimbursed at 70% of reasonable and customary charges, after you meet your deductible. Benefit is limited to 50 visits per calendar year.

The copays and coinsurance for out-patient psychiatric care benefits are not applied towards your out-of-pocket maximums.

Mental Health counseling must be provided by a recognized counselor.

Aetna recognizes the following practitioners as legally qualified physicians for counseling when they are:

- rendering a service covered by the policy,
 - licensed by the state or jurisdiction of practice; and
 - practicing within the scope of their license.
-
- Licensed Professional Counselor LPC
 - Medical Doctor M.D
 - Osteopath D.O
 - Psychologist Ph.D.,
 - Social Worker M.S.W.

Telephonic counseling is available if the therapist has a pre-existing, face-to-face relationship with the patient prior to starting telephone therapy and there are extenuating circumstances that prevent face-to-face sessions.

Maximums (Combined In- and Out-of-Network)

The following Plan maximums refer to any combination of in- and out-of-network Mental Health and/or Substance Abuse services per covered individual:

In-patient: 30 days maximum per calendar year.

Out-patient: 50 visits maximum per calendar year.

Organ Transplants

Transplants that are non-experimental or non-investigational are a Covered Benefit. Coverage for a transplant where a Member is the recipient includes coverage for the medical and surgical expenses of a live donor, to the extent these services are not covered by another plan or program.

Aetna covers the following services when the member is the recipient of (or a potential recipient for) a covered organ or tissue transplant:

- Compatibility testing of prospective organ/tissue donors who are members of the immediate family (first-degree relatives, that is, parents, siblings and children) of a member selected for an organ transplant.
- Live organ/tissue donor fees.
- Cadaveric organ/tissue procurement preservation, storage and transportation fees as billed by the Organ Procurement Organization (OPO).
- Charges for activating the donor search process for donors in the registry, HLA-DR sample procurement and typing, donor physical examinations and laboratory tests, as well as bone marrow/stem cell procurement.

Note: Harvesting of tissue (stem cell) for storage purposes only is not eligible for coverage unless the affected Aetna member has a documented disease diagnosis that may require the use of that stored tissue. Requests for coverage of tissue storage for longer than 12 months are reviewed by Aetna's National Medical Excellence unit for medical necessity. If both the donor and the transplant recipient are covered by this plan, donor expenses are attributed to the transplant recipient's coverage. This plan does not extend coverage for donor services when the transplant recipient is not our member.

Organ Transplant National Medical Excellence Program ® (NME)

The NME Program coordinates all solid organ and bone marrow transplants and other specialized care that can not be provided within an NME Patient's local geographic area. When care is directed to a facility ("Medical Facility") more than 100 miles from the person's home, this Plan will pay a benefit for Travel and Lodging Expenses, but only to the extent described below.

Travel Expenses

These are expenses incurred by an NME Patient for transportation between his or her home and the Medical Facility to receive services in connection with a procedure or treatment. Also included are expenses incurred by a Companion for transportation when traveling to and from an NME Patient's home and the Medical Facility to receive such services.

Lodging Expenses

These are expenses incurred by an NME Patient for lodging away from home while traveling between his or her home and the Medical Facility to receive services in connection with a procedure or treatment. The benefit payable for these expenses will not exceed the Lodging Expenses Maximum of \$50 per person per night.

Also included are expenses incurred by a Companion for lodging away from home:

- while traveling with an NME Patient between the NME Patient's home and the Medical Facility to receive services in connection with any listed procedure or treatment; or
- when the Companion's presence is required to enable an NME Patient to receive such services from the Medical Facility on an inpatient or outpatient basis.

The benefit payable for these expenses will not exceed the Lodging Expenses Maximum of \$50 per person per night.

For the purpose of determining NME Travel Expenses or Lodging Expenses, a hospital or other temporary residence from which an NME Patient travels in order to begin a period of treatment at the Medical Facility, or to which he or she travels after discharge at the end of a period of treatment, will be considered to be the NME Patient's home.

Travel and Lodging Benefit Maximum

For all Travel Expenses and Lodging Expenses incurred in connection with any one procedure or treatment type:

- The total benefit payable will not exceed the Travel and Lodging Maximum per episode of care.
- Benefits will be payable only for such expenses incurred during a period which begins on the day a covered person becomes an NME Patient and ends on the earlier to occur of:
 - one year after the day the procedure is performed; or
 - the date the NME Patient ceases to receive any services from the facility in connection with the procedure.

Limitations

Travel Expenses and Lodging Expenses do not include, and no benefits are payable for, any charges which are included as Covered Medical Expenses under any other part of this Plan.

Travel Expenses do not include expenses incurred by more than one Companion who is traveling with the NME Patient.

Lodging Expenses do not include expenses incurred by more than one Companion per night.

Institutes of Excellence (IOE)

The Institutes of Excellence (IOE) transplant network is Aetna's national network for transplants and transplant-related services, including evaluation and follow-up care. Hospitals that have been selected to participate in our IOE transplant network have met enhanced quality thresholds for volumes and outcomes. Facilities have been contracted on a transplant-specific basis and are considered to be participating ONLY for the specific transplants for which they are contracted.

Only facilities designated for the IOE transplant network are considered participating for transplant-related services. Therefore, hospitals that participate in Aetna's network that are not designated as IOE facilities are considered *non-participating* for transplant-related services. Additionally, if a member utilizes an IOE for a transplant for which the facility is NOT specifically contracted, they are considered to be out-of-network and the out-of-network benefit level applies.

The initial criterion for a facility's inclusion in the IOE transplant network is:

- Enhanced organ-specific credentialing and quality standards;
- The National availability of and need for transplant facilities, on a transplant type specific basis.

An Institutes of Excellence transplant facility listing sorted by transplant type and by state is included on DocFind at, http://www.aetna.com/docfind/institutes_of_excellence.html.

Subrogation and Right of Recovery

Definitions

As used throughout this provision, the term "Responsible Party" means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person's injury, illness, or condition. The term "Responsible Party" includes the liability insurer of such party or any insurance coverage.

For purposes of this provision, the term "Insurance Coverage" refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

For purposes of this provision, a "Covered Person" includes anyone on whose behalf the plan pays or provides any benefit including, but not limited to, the minor child or dependent of any plan member or person entitled to receive any benefits from the plan.

Subrogation

Immediately upon paying or providing any benefit under this plan, the plan shall be subrogated to (stand in the place of) all rights of recovery a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to a Covered Person due to a Covered Person's injury, illness, or condition to the full extent of benefits provided or to be provided by the plan.

Reimbursement

In addition, if a Covered Person receives any payment from any Responsible Party or Insurance Coverage as a result of an injury, illness, or condition, the plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts this plan has paid and will pay as a result of that injury, illness, or condition, up to and including the full amount the Covered Person receives from any Responsible Party.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person agrees that if he or she receives any payment from any Responsible Party as a result of an injury, illness, or condition, he or she will serve as a constructive trustee over the funds that constitutes such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the plan.

Lien Rights

Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury, or condition for which the Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise related to treatment for any illness, injury, or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, the Covered Person, the Covered Person's representative or agent; Responsible Party; Responsible Party's insurer, representative, or agent; and/or any other source possessing funds representing the amount of benefits paid by the plan.

First-Priority Claim

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person acknowledges that this plan's recovery rights are a first priority claim against all Responsible Parties and are to be paid to the plan before any other claim for the Covered Person's damages. This plan shall be entitled to full reimbursement on a first-dollar basis from any Responsible Party's payments, even if such payment to the plan will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only.

Cooperation

The Covered Person shall fully cooperate with the plan's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness, or condition sustained by the Covered Person. The Covered Person and his or her agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request. Failure to provide this information may result in the termination of health benefits for the Covered Person or the institution of court proceedings against the Covered Person.

The Covered Person shall do nothing to prejudice the plan's subrogation or recovery interest or to prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan.

The Covered Person acknowledges that the plan has the right to conduct an investigation regarding the injury, illness, or condition to identify any Responsible Party. The plan reserves the right to notify responsible Party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future domicile.

Exclusion

This plan does not cover services and supplies, in the opinion of the Claims Administrator or its authorized representative, that are associated with injuries, illness, or conditions suffered due to the acts or omissions of a third party.

Prescription Drugs

Pharmacy Card

As a participant in the Lehman Brothers Medical Plan, you will receive a Prescription Benefit Card, separate from your Aetna ID card. Medco has established an extensive national network of preferred pharmacies that will accept the Prescription Benefit Card.

By using your Lehman Brothers Prescription Benefit Card at any of the Medco network pharmacies, your cost for a 30-day supply will be:

Type of Medication	Your Cost
Generic	10% of the total cost; maximum \$100
Preferred brand	25% of the total cost; maximum \$100
Non-preferred brand	50% of the total cost; maximum \$100

If you have a prescription filled at a non-network pharmacy, or if you have a prescription filled at a network pharmacy without your Lehman Brothers Prescription Benefit Card, your reimbursement will be paid at the same level as if you purchased your prescription at a network pharmacy with your Lehman Brothers Prescription Benefit Card. You will be responsible for any payment above that amount.

For example: A generic drug is sold at an in-network pharmacy to Plan participants for the reduced amount of \$40. Therefore, if you purchased this drug at an in-network pharmacy with your Lehman Brothers Prescription Benefit Card, you would be responsible for your \$4 copay and the Plan will pay the remaining balance of \$36. If you bought the same drug at a non-network pharmacy for \$80, the plan would then reimburse you \$36 and you would be responsible for the remaining balance of \$44.

Copay Reduction/Waiver Programs

At times the Plan may decide to offer a special program to waive or reduce the copay for all participants in a certain situation (e.g. all participants taking a certain class of drugs, all participants filling prescriptions for a specific maintenance medication at retail pharmacies, all participants taking a brand name drug in a drug class with a newly available generic). These programs will be on a Plan basis and may be offered for whatever length of time the Plan Administrator deems appropriate.

Preferred Drugs

A preferred drug is any brand name prescription medication that Medco has evaluated for its therapeutic and economic value and has classified as "Preferred." Brand prescription drugs that are not classified as preferred are "non-preferred." In general, brand medications cost significantly more than generics. However, you will pay less for a preferred brand than you would for an equivalent non-preferred brand.

To find out whether your specific brand medication is preferred or non-preferred, refer to the Medco Preferred Prescriptions Drug list on their web site, www.medco.com (Note: you will need to establish a user name and password in order to access this site).

How Does the Card Work?

Use a Medco network pharmacy when filling prescriptions. Since the Medco network is nationwide, you can purchase your prescriptions even while traveling.

Present your card to your pharmacist at the same time you fill your prescriptions. Your pharmacist will ask for information about you and your covered dependents (if applicable).

Mail Order Prescription Drug Program

The Mail Order Prescription Drug Program, offered as part of the Lehman Brothers Medical Plan, is a convenient and economical way to purchase your long-term maintenance medications. You may order up to a 90-day supply (which may be filled up to four times within a 12-month period) from the mail order plan. Your cost per 90-day supply will be:

Type of Medication	Your Cost
Generic	10% of the total cost; maximum \$250
Preferred brand	25% of the total cost; maximum \$250
Non-preferred brand	50% of the total cost; maximum \$250

How Does the Mail Service Program Work?

1. When your physician writes a prescription for a maintenance medication: if appropriate, ask him/her to write your prescription for up to a 90-day supply, with up to three (3) refills. For a new prescription, you may want to have your physician write two (2) prescriptions: one for a minimum of two (2) weeks' worth of medication that you can fill immediately at a retail pharmacy using your Prescription Benefit Card, and, and one for up to 90 days that you can fill using the Mail Service Program (delivery may take up to 2 weeks).
2. Complete the Medco Order Form for your first mail service order.
3. For new prescriptions, submit a new, original prescription with your order form.
4. Make your check payable to Medco, or furnish your credit card information in the section provided
5. Mail the completed form (and check, if applicable) to the address shown on the order form.

For rapid refills, visit www.medco.com or call 800-597-0179. Please allow 10-14 days from the date you mail your prescription order for delivery; overnight delivery service is available at an additional cost.

Internet Access to Your Prescriptions – www.medco.com

Medco has an integrated Internet site, www.medco.com. Through this site, you will be able to access your personal profile, including prescriptions filled at both the retail level as well as mail order for each covered family member. The information on Medco.com is confidential, and each family member can select an individual password.

Valuable information available on the Medco web site include:

- Information regarding prescription drugs, their uses as well as interactions;
- A disease reference guide;
- The ability to refill and track mail order prescriptions;
- A retail pharmacy locator; and
- The ability to purchase non-covered items (such as vitamins or health and beauty aids) through an alliance with DrugStore.com.

Prescription Drugs That Are Covered

Generally, drugs approved by the FDA that are prescribed by a physician are covered; this can include insulin and disposable syringes. Please note that some drugs may require prior authorization to determine eligibility for coverage and some drugs are only covered for specific quantities, for a specific period of time, or for the type of treatment which it was approved by the FDA (e.g., not for an off-label use).

Prescription Drugs That Are Not Covered

- Dietary supplements
- Immunization agents, biological sera, blood or blood plasma. (These items are covered as medical expenses under the Lehman Brothers Medical Plan only when they are dispensed during a certified hospital stay or physician's office visit.)
- Infertility medications, except in conjunction with the Infertility Program.
- Minoxidil (Rogaine®) for alopecia.
- Tretinoin (Retin-A®) in all dosage forms, for individuals 35 years of age or older.
- Anti-wrinkle agents such as Renova®, regardless of intended use.
- Drugs to treat impotency for individuals under 18 years old.
- Emergency contraceptives through mail order (only covered through retail pharmacies)
- Over-the-counter (non-prescription) medications.
- Therapeutic devices and appliances (except inhaler spacers).
- Blood Glucose Monitors.
- Topical dental fluoride treatments.
- Charges for administering or injecting a drug.
- Drugs labeled Caution limited by federal law to investigational use or experimental drugs. See the Experimental Services and Supplies section for exceptions.
- Drugs administered in hospitals, doctors' offices, clinics or similar institutions.
- Any prescription refilled in excess of the number specified by the physician or any refill dispensed more than one (1) year after the original date of prescription.

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses, and
- Treatment of physician complications of the mastectomy, including lymphedema

Such coverage will be subject to annual deductibles and coinsurance provisions as deemed appropriate and are consistent with those established for other benefits under the Lehman Brothers Medical Plan.

Expenses Not Covered

The following pages contain a partial list of expenses not covered under the Lehman Brothers Medical Plan. Other exclusions are listed under “Covered Expenses” in the Durable Medical and Surgical Equipment section and the Prescription Drugs section. Copies of the Aetna Clinical Policy Bulletins, detailing specific exclusions, are available without charge from the HR Service Center.

Medical Necessity

Services or supplies that Aetna determines are not medically necessary are not covered under the Lehman Brothers Medical Plan regardless of who prescribes, recommends or performs these services.

In no event will the following services or supplies be considered to be medically necessary:

- Those that do not require the technical skills of a medical, mental health or dental professional.
- Those excluded under an Aetna Clinical Policy Bulletin.
- Those furnished mainly for the personal comfort or convenience of the patient, any person who cares for the patient, any person who is part of the patient’s family, any health care provider or health care facility.
- Those furnished solely because the person is an in-patient on any day on which the person’s disease or injury could safely and adequately be diagnosed or treated while not confined.
- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician’s or a dentist’s office or other less costly setting.

Reasonable and Customary Limits

Out-of-network expenses in excess of the reasonable and customary limits defined in the Reasonable and Customary Charges section are not covered under the Lehman Brothers Medical Plan.

Experimental Services and Supplies

The Lehman Brothers Medical Plan does not cover any drug, device, procedure or treatment if:

- There are insufficient outcome data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
- If required by the U.S. Food and Drug Administration (FDA), approval has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes; or
- The written protocol or protocols used by the treating facility or the protocol or protocols of any other facility studying the same drug, device, procedure or treatment states that it is experimental, investigational or for research purposes.

The experimental exclusion will not apply if one of the two following sets of criteria are met:

- All of the following criteria are satisfied:
 - The patient has a disease which is expected to cause death within one year in the absence of effective treatment; and

- The usual modalities of conventional, standard treatment have been unsuccessful; and
- The proposed treatment is promising and likely to be effective for the patient. A promising treatment is one where Aetna has determined that it has shown effectiveness as supported in credible peer reviewed literature or by the credible medical opinion of independent medical experts in the relevant specialty.

or

- The patient is to be treated as part of a clinical trial satisfying all of the following criteria:
 - The drug, device, therapy or procedure under investigation is under current review by the FDA and has been determined to be safe for human use; and
 - The clinical trial has been approved by an Institutional Review Board that will oversee the investigation; and
 - There is credible evidence in the peer-reviewed medical literature showing benefit from the proposed treatment; and
 - The clinical trial is sponsored by the National Cancer Institute or similar national cooperative body, and conforms to the rigorous independent oversight criteria as defined by that body for the performance of clinical trials.

Behavior Modification Therapy

The term “behavior modification therapy” refers to any course of therapy that attempts to modify observable, maladjusted patterns of behavior. Such therapy, including assertiveness training, aversion therapy, sensory integration therapy and adaptive behavioral analysis for children with autism or developmental disorders, is not covered under the Plan.

Custodial Care

“Custodial care” is defined as services and supplies furnished mainly to help a patient in the activities of daily living. This includes room and board and other institutional care. Custodial care is not covered regardless of who prescribes, recommends or performs these services.

Private Duty Nursing

Charges for private duty nursing are not covered unless Aetna precertifies them as a replacement for other, more expensive care.

End Stage Renal Disease

Individuals who have been diagnosed as having end stage renal disease are eligible for coverage under Medicare. Therefore, Medicare coverage is primary for all charges related to the treatment of end stage renal disease patients.

Temporomandibular Joint Syndrome

Most services for Temporomandibular Joint Syndrome (TMJ) are not covered under the Lehman Brothers Medical Plan. See the Teeth, Mouth and Jaws section for details.

Services and supplies primarily or exclusively used to permanently alter occlusion and/or reposition the lower jaw, including appliances or orthodontic banding and wiring, as well as myofunctional therapy, are considered dental in nature and are not covered under this Plan, whether or not the purpose of such service or supply is to relieve pain. See the Teeth, Mouth and Jaws section for further dental exclusions.

Teeth, Mouth and Jaws

Expenses for the treatment of the mouth, jaws and teeth are Covered Medical Expenses, but only those for services rendered and supplies needed for the treatment of or related to the conditions of the teeth, mouth, jaws, jaw joints or supporting tissues (this includes bones, muscles and nerves).

For these expenses, physician includes a dentist.

Hospital services and supplies received for an inpatient hospital confinement required because of the person's condition are covered including surgery need to:

- Treat a fracture, dislocation or wound;
- Cut-out cysts, tumors or other diseased tissues;
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Dental services that are appropriate, necessary, and required as the result of an accident are covered, including:

- Dentist's or oral surgeon's charges for repair of natural teeth or other tissues of the mouth;
- Cost of installing initial dentures, fixed bridgework, or crowns if they are necessary part of the repair work;
- Replacement of free-standing crowns or retainer abutments for fixed bridgework only when the injury requires re-preparation of the natural teeth.

The accident causing the injury must occur while the person is insured under the plan and treatment must be performed:

- During the calendar year of the accident, or
- The following calendar year.

In addition to the exclusions mentioned under the "Temporomandibular Joint Syndrome" section above, the following services and supplies are **not covered** expenses under the Lehman Brothers Medical Plan:

- Dental care, except for the repair of healthy, natural teeth damaged due to an injury suffered while covered under the Plan. (Benefits are not available for accidental injury of non-natural teeth and/or dentures.)
- The following dental work, except when provided for the repair of healthy, natural teeth damaged due to an injury suffered while covered under the Plan:
 - In-mouth appliances, crowns, bridgework, dentures, tooth restorations or any related fitting or adjustment services, whether or not the purpose of such service or supply is to relieve pain;

- Root canal therapy; and
- Tooth removal.
- Charges to remove, repair, replace, restore or reposition teeth lost or damaged in the course of biting or chewing.
- Charges to repair, replace or restore fillings, crowns, dentures or bridgework.
- Periodontal treatment.

How to Determine if an Out-of-Network Expenses is Covered

Before any major out-of-network treatment begins, you or your doctor should contact Aetna to determine whether the procedure is covered under the Plan and determine the reasonable and customary charge for such services. Contact Member Services at 800-345-4432 to obtain a “pretreatment estimate” form for any procedure.

Other Exclusions

- Services rendered by a health care provider who is not licensed to render such specific services.
- Services rendered by a health care provider who is not licensed to render such services in the state where the services were performed (e.g. licensed in NJ only, but performs the services in NY).
- Services provided and procedures performed before coverage begins or after it ends.
- Charges for failure to keep a scheduled appointment.
- Eyeglasses, or examinations for their prescription or fitting.
- Vitamins.
- Cosmetic surgery (unless reconstructive surgery is required following a mastectomy or as a result of an injury that occurs while you are covered under any Lehman Brothers Medical Plan option).
- Job-related accidents or illnesses covered by workers’ compensation, or expenses which would have been covered by a state workers’ compensation or private Workers’ Compensation policy.
- Charges for services which are determined by Aetna to be educational in nature.
- Treatment for congenital disorders, birth defects and developmental delays.
- Emergency room services for non-emergencies. See the Emergency Care section for the definition of medical emergency.
- Emergency Medical Technician or Emergency Medical Service charges, except in conjunction with covered ambulance charges as described under Emergency Care.
- Exercise equipment, such as treadmills.
- Enteral Formula, unless ordered by a physician stating it is necessary for the patient whose condition would cause them to be malnourished or suffer disorders resulting in chronic disability, mental retardation or death.

How to Submit Your Medical Claims

The following procedures are applicable only to out-of-network claims. Out-of-network benefits are not available for prescription drugs. See the Prescription Drugs section for details on prescription drug coverage.

In-Hospital Charges

When admitted, present your Aetna ID card to the hospital admissions office. The hospital should bill Aetna directly. An out-of-network hospital may ask you to provide payment equal to your deductible (if not already met) and 30% of the anticipated charges, up to your out-of-pocket maximum, and any expenses that are not covered (such as private room charges). Aetna will make all payments directly to the hospital.

If you require emergency treatment and/or emergency admission at a non-network hospital, you are still entitled to in-network benefits. You or the hospital need to call the toll-free precertification number on your Aetna ID card for instructions on how to process non-network emergency claims. See the Emergency Care section under “Covered Expenses” for details.

Physician and Other Medical Charges

Please do not submit any claims to Aetna until you have bills which exceed your annual deductible.

Claims should be filed in the same calendar year in which you incur the expenses. Claims must be filed within two (2) years of the date of service or they will not be eligible for reimbursement.

Please use the proper claim form. Complete an Aetna Medical Benefits Request form (“claim form”) for each claim you file. Aetna will not process claims submitted without a claim form. The address you list on the claim form is the address used for any reimbursement due you. You may obtain claim forms on Lehman & You, Frequently Requested Forms, under Claim Forms.

Always include your (the employee’s) member ID number on your claim form. It serves as the identification number for you and your covered dependents. Without it, Aetna cannot process claims for you or any of your covered dependents.

Attach complete, itemized bills to your claim form. Itemized bills should include the following information: doctor’s name and tax identification number, employee’s name, employee’s Social Security number, patient’s name, date of service or purchase, condition being treated or diagnosis and the charge for each service or supply.

Send only original bills, not photocopies. Keep copies of all bills and claim forms for your own files.

Mail the claim form and itemized bills to the Lehman Brothers Claim Unit address that is listed on the form.

Retiree Medical Coverage

If you retire, you may be eligible to receive retiree medical coverage for yourself and your eligible dependents.

1. You are eligible to enroll in the Retiree Healthcare Program if you are an employee of Lehman Brothers Inc. and only if you meet all three of the following criteria:
 - You were hired by the Firm prior to December 1, 1999, and
 - At the time you leave employment you have been covered by one of the Firm-sponsored medical plans (excluding flexible spending accounts) for at least one year; and

- At the time you leave employment you satisfy what is known as the “rule of 75”. That is your age plus number of years of service with the Firm equal at least 75, and you are a minimum of age 55, and you have a minimum of 10 years of service to be eligible.

If you worked for Lehman Brothers or one of Lehman Brothers’ predecessor firms, terminated your employment with the Firm, and then rejoined the Firm at a later date, you have incurred a “Break in Service.”

For purposes of the Retiree Healthcare Program, if your prior service with the Firm is greater than your time away, your prior service will be counted towards eligibility and the Rule of 75. For example, if you worked for the Firm for eight years, left for two years and were then rehired, your service calculation will include all of your service, even if you were rehired after December 1, 1999.

If your prior length of service with the Firm is less than your time away, your prior service will not be counted toward the rule of 75. For example, if you worked for the firm for two years, left the Firm for three years, and then were rehired, your service calculation will only include the service after your rehire date. If your rehire date was after December 1, 1999, you are not eligible for Retiree Healthcare coverage.

Your eligible dependents include your spouse/domestic partner and unmarried dependent children up to the age of 19 or 25 if they are a full-time student. In order to be eligible for coverage, your dependents must have been covered under a Lehman Brothers Medical Plan for one year or more prior to the time you retire. If you marry or remarry after retiring, you cannot add your new spouse or dependents to your Retiree Healthcare coverage.

2. You are eligible to enroll in the Retiree Medical Program if you are an employee of Lehman Brothers Inc. and only if you meet both of the following criteria:
 - At the time you leave employment you have been covered by one of the Firm-sponsored medical plans for at least one year; and
 - You met the Rule of 75 on or before December 31, 1991.

If you worked for Lehman Brothers or one of Lehman Brothers’ predecessor firms, terminated your employment with the Firm, and then rejoined the Firm at a later date, you have incurred a “Break in Service.” For purposes of the Retiree Medical Program, if your prior service with the Firm is greater than your time away, your prior service will be counted towards eligibility and the Rule of 75. If your prior length of service with the Firm is less than your time away, your prior service will not be counted toward the rule of 75.

Your eligible dependents include your spouse/domestic partner and unmarried dependent children up to the age of 19 or 25 if they are a full-time student. In order to be eligible for coverage, your dependents must have been covered under a Lehman Brothers Medical Plan for one year or more prior to the time you retire. If you marry or remarry after retiring, you cannot add your new spouse or dependents to your Retiree Medical Program coverage.

3. You are eligible to enroll in the Neuberger Berman Retiree Program if you are an employee of Neuberger Berman and only if you meet all the following criteria:
 - At the time you leave employment you satisfy what is known as the “Rule of 70.” That is, your age plus number of years of service with the Firm equal at least 70, and you are a minimum age of 55 and you have a minimum of 10 years of service to be eligible, and
 - You met the Rule of 70 on or before October 31, 2003.

Coverage for retirees and spouses continues until age 65. Coverage for unmarried dependent children continues until they reach age 19 or 25 if they are a full-time student. In order to be eligible for coverage, your dependents must have been covered under a Lehman Brothers Inc. group medical plan for one year or more prior to the time you retire. If you marry or remarry after retiring, you cannot add your new spouse or dependents to your Neuberger Berman Retiree Medical Program coverage.

As with the plans covering active employees, Lehman Brothers reserves the right to change or discontinue any of these benefits and programs at any time without prior notice. This includes, but is not limited to, the level of benefits, eligibility for benefits and any cost to participants. The fact of your retirement does not provide you with any vested right to any retiree coverages.

Complete details regarding these plans can be found in their individual summary plan descriptions available by contacting the HR Service Center at 212-536-2363 or Hrservices@lehman.com.

Glossary

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. If a definition appears in a benefit section and also appears in the Glossary, the definition in the benefit section will apply in lieu of the definition in the Glossary.

Board and Room Charges. Charges made by an institution for board and room and other necessary services and supplies. They must be regularly made at a daily or weekly rate.

Companion. A person whose presence as a Companion or caregiver is necessary to enable an NME Patient:

- to receive services in connection with an NME procedure or treatment on an inpatient or outpatient basis; or
- to travel to and from the facility where treatment is given.

Convalescent Facility. An institution that:

- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:
 - professional nursing care by a R.N., or by a L.P.N. directed by a full-time R.N.; and
 - physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time R.N.
- Is supervised full-time by a physician or R.N.
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.
- Makes charges.

Copay. A fee, charged to a person, which represents a portion of the applicable expense.

Custodial Care. Services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes board and room and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:

- by whom they are prescribed; or
- by whom they are recommended; or
- by whom or by which they are performed.

Dentist. A legally qualified dentist. Also, a physician who is licensed to do the dental work he or she performs.

Durable Medical and Surgical Equipment. No more than one item of equipment for the same or similar purpose, and the accessories needed to operate it, that is:

- made to withstand prolonged use;
- made for and mainly used in the treatment of a disease or injury;
- suited for use in the home;
- not normally of use to persons who do not have a disease or injury;
- not for use in altering air quality or temperature;
- not for exercise or training.

Not included is equipment such as: whirlpools; portable whirlpool pumps; sauna baths; massage devices; overbed tables; elevators; communication aids; vision aids; and telephone alert systems.

Effective Treatment of Alcoholism or Drug Abuse. A program of alcoholism or drug abuse therapy that is prescribed and supervised by a physician and either:

- has a follow-up therapy program directed by a physician on at least a monthly basis; or
- includes meetings at least twice a month with organizations devoted to the treatment of alcoholism or drug abuse.

These are not effective treatment:

- Detoxification. This means mainly treating the aftereffects of a specific episode of alcoholism or drug abuse.
- Maintenance care. This means providing an environment free of alcohol or drugs.
- Emergency Admission. When a physician admits the person to the hospital or treatment facility right after the sudden and, at that time, unexpected onset of a change in the person's physical or mental condition:
 - which requires confinement right away as a full-time inpatient; and
 - for which if immediate inpatient care was not given could, as determined by Aetna, reasonably be expected to result in:
 - placing the person's health in serious jeopardy; or
 - serious impairment to bodily function; or
 - serious dysfunction of a body part or organ; or
 - in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency Care. Treatment given in a hospital's emergency room to evaluate and treat medical conditions of a recent onset and severity, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the person's health in serious jeopardy; or
- serious impairment to bodily function; or
- serious dysfunction of a body part or organ; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency Condition. A recent and severe medical condition, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the person's health in serious jeopardy; or
- serious impairment to bodily function; or

- serious dysfunction of a body part or organ; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Home Health Care Agency. An agency that:

- mainly provides skilled nursing and other therapeutic services; and
- is associated with a professional group which makes policy; this group must have at least one physician and one R.N.; and
- has full-time supervision by a physician or a R.N.; and
- keeps complete medical records on each person; and
- has a full-time administrator; and
- meets licensing standards.

Home Health Care Plan. A plan that provides for care and treatment of a disease or injury. The care and treatment must be:

- prescribed in writing by the attending physician; and
- an alternative to confinement in a hospital or convalescent facility.

Hospice Care. Care given to a terminally ill person by or under arrangements with a Hospice Care Agency. The care must be part of a Hospice Care Program.

Hospice Care Agency. An agency or organization which:

- Has Hospice Care available 24 hours a day.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Provides:
 - skilled nursing services; and
 - medical social services; and
 - psychological and dietary counseling.
- Provides or arranges for other services which will include:
 - services of a physician; and
 - physical and occupational therapy; and
 - part-time home health aide services which mainly consist of caring for terminally ill persons; and
 - inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has personnel which include at least:
 - one physician; and
 - one R.N.; and
 - one licensed or certified social worker employed by the Agency.
- Establishes policies governing the provision of Hospice Care.
- Assesses the patient's medical and social needs.
- Develops a Hospice Care Program to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by physicians, other than those who own or direct the Agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Utilizes volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Hospice Care Program. A written plan of Hospice Care, which:

- Is established by and reviewed from time to time by:
 - a physician attending the person; and
 - appropriate personnel of a Hospice Care Agency.
- Is designed to provide:
 - palliative and supportive care to terminally ill persons; and
 - supportive care to their families.
- Includes:
 - an assessment of the person's medical and social needs; and
 - a description of the care to be given to meet those needs.

Hospice Facility. A facility, or distinct part of a facility, which:

- Mainly provides inpatient Hospice Care to terminally ill persons.
- Charges its patients.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program; this includes reviews by physicians other than those who own or direct the facility.
- Is run by a staff of physicians; at least one such physician must be on call at all times.
- Provides, 24 hours a day, nursing services under the direction of a R.N.
- Has a full-time administrator.

Hospital. A facility that:

- Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons.
- Is supervised by a staff of physicians.
- Provides 24 hour a day R.N. service.
- Is accredited as a hospital by either the joint Commission on Accreditation of Hospitals or the Bureau of Hospitals of the American Osteopathic Association.
- May be a general, acute care institution or a specialty institution provided that in either case, it is appropriately accredited as listed above and licensed by the proper state authorities.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home.
- Makes charges.

L.P.N. A licensed practical nurse.

Mental Disorder. A disease commonly understood to be a mental disorder whether or not it has a physiological or organic basis and for which treatment is generally provided by or under the direction of a mental health professional such as a psychiatrist, a psychologist or a psychiatric social worker. A mental disorder includes; but is not limited to:

- Alcoholism and drug abuse.
- Schizophrenia.
- Bipolar disorder.
- Pervasive Mental Developmental Disorder (Autism).
- Panic disorder.
- Major depressive disorder.
- Psychotic depression.
- Obsessive compulsive disorder.

For the purposes of benefits under this Plan, mental disorder will include alcoholism and drug abuse only if any separate benefit for a particular type of treatment does not apply to alcoholism and drug abuse.

NME Patient. A person who:

- requires any of the NME procedure and treatment types for which the charges are a Covered Medical Expense; and
- contacts Aetna and is approved by Aetna as an **NME Patient**; and
- agrees to have the procedure or treatment performed in a **hospital** designated by Aetna as the most appropriate facility.

Necessary. A service or supply furnished by a particular provider is necessary if Aetna determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved.

To be appropriate, the service or supply must:

- be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition;
- be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and
- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:

- information provided on the affected person's health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized healthcare organizations that include supporting scientific data;
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;
- the opinion of health professionals in the generally recognized health specialty involved; and
- any other relevant information brought to Aetna's attention.

In no event will the following services or supplies be considered to be necessary:

- those that do not require the technical skills of a medical, a mental health or a dental professional; or
- those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any healthcare provider or healthcare facility; or
- those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined; or
- those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

Negotiated Charge. The maximum charge a Preferred Care Provider has agreed to make as to any service or supply for the purpose of the benefits under this Plan.

Non-Occupational Disease. A non-occupational disease is a disease that does not:

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from a disease that does.

A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- is covered under any type of workers' compensation law; and
- is not covered for that disease under such law.

Non-Occupational Injury. An accidental bodily injury that does not:

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from an injury which does.

Non-Preferred Care. A health care service or supply furnished by a health care provider that is not Preferred Care.

Non-Preferred Care Provider. A health care provider that has not contracted to furnish services or supplies at a Negotiated Charge.

Non-Preferred Pharmacy. A pharmacy that is not party to a contract with the Plan, or a pharmacy which is party to such a contract but does not dispense prescription drugs in accordance with its terms.

Non-Specialist. A physician who is not a specialist.

Non-urgent Admission. One which is not an emergency admission or an urgent admission.

Orthodontic Treatment. Any medical service or supply, or dental service or supply, furnished to prevent or to diagnose or to correct a misalignment:

- of the teeth; or
- of the bite; or
- of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain. Not included is:

- the installation of a space maintainer; or
- a surgical procedure to correct malocclusion.

Physician. A legally qualified physician, that is licensed in the state in which the services are provided.

Preferred Care. A health care service or supply furnished by:

- A person's Primary Care Physician or any other Preferred Care Provider.
- A Non-Preferred Care Provider on the referral of the person's Primary Care Physician and if approved by Aetna.
- Any health care provider for an emergency condition when travel to a Preferred Care Provider or referral by a person's Primary Care Physician prior to treatment is not feasible and
- A Non-Preferred Urgent Care Provider when travel to a Preferred Urgent Care Provider for treatment is not feasible.

Preferred Care is also care which is recommended and approved by the BHCC.

Preferred Care Provider. This is a health care provider that has contracted to furnish services or supplies for a Negotiated Charge; but only if the provider is, with Aetna's consent, included in the Directory as a Preferred Care Provider for:

- the service or supply involved; and
- the class of employees of which you are member.

Psychiatric Physician. A physician who:

- specializes in psychiatry; or
- has the training or experience to do the required evaluation and treatment of mental illness.

R.N. A registered nurse.

Recognized Charge (also referred to as Reasonable & Customary)

Only that part of a charge made by a physician or dentist which is recognized is covered. The recognized charge for a service or supply is the lowest of:

- the provider's usual charge for furnishing it; and
- the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- the charge Aetna determines to be the Recognized Charge Percentage made for that service or supply.

In determining the recognized charge for a service or supply that is:

- unusual; or
- not often provided in the area; or
- provided by only a small number of providers in the area;

Aetna may take into account factors, such as:

- the complexity;
- the degree of skill needed;
- the type of specialty of the provider; and
- the recognized charge in other areas.

In some circumstances, Aetna may have an agreement with a provider (either directly, or indirectly through a third party) which sets the rate that Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the recognized charge is the rate established in such agreement.

Semiprivate Rate. The charge for board and room which an institution applies to the most beds in its semiprivate rooms with 2 or more beds. If there are no such rooms, Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

Service Area. The geographic area, as determined by Aetna in which Preferred Care Providers for this Plan are located.

Short Procedure Unit.

- Services involve use of an operating room for surgery that is completed and the patient is discharged on the same day.
- Distinguished from "outpatient department" which is for more minor procedures that generally require no or local anesthesia. (Examples of outpatient procedures performed in the outpatient department: endoscopy, colonoscopy, knee arthroscopy and chemotherapy administration)
- Generally involves general anesthesia.
- Is licensed as an ambulatory surgical facility by the jurisdiction it is in (states with licensing requirements),

- Is set up, equipped and run solely as a setting for surgery.

Specialist. A physician who:

- practices in any generally accepted medical or surgical sub-specialty; and
- is providing other than routine medical care.

A physician who:

- practices in such a sub-specialty; and
- is providing routine medical care (such as could be given by a primary care physician),

will not be considered a Specialist for purposes of applying this plan's **copay** provisions.

Terminally Ill. This is a medical prognosis of 6 months or less to live.

Treatment Facility (Alcoholism Or Drug Abuse). An institution that:

- Mainly provides a program for diagnosis, evaluation, and effective treatment of alcoholism or drug abuse.
- Makes charges.
- Meets licensing standards.
- Prepares and maintains a written plan of treatment for each patient. The plan must be based on medical, psychological and social needs. It must be supervised by a physician.
- Provides, on the premises, 24 hours a day:
 - Detoxification services needed with its effective treatment program.
 - Infirmiry-level medical services. Also, it provides, or arranges with a hospital in the area for, any other medical services that may be required.
 - Supervision by a staff of physicians.
 - Skilled nursing care by licensed nurses who are directed by a full-time R.N.

Treatment Facility (Mental Disorder). An institution that:

- Mainly provides a program for the diagnosis, evaluation, and effective treatment of mental disorders.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmiry-level medical services. Also, it provides, or arranges with a hospital in the area for, any other medical service that may be required.
- Is supervised full-time by a psychiatrist who is responsible for patient care and is there regularly.
- Is staffed by psychiatric physicians involved in care and treatment.
- Has a psychiatric physician present during the whole treatment day.
- Provides, at all times, psychiatric social work and nursing services.
- Provides, at all times, skilled nursing care by licensed nurses who are supervised by a full-time R.N.
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a psychiatric physician.
- Makes charges.
- Meets licensing standards.

Urgent Admission. One where the physician admits the person to the hospital due to:

- the onset of or change in a disease; or
- the diagnosis of a disease; or
- an injury caused by an accident;

which, while not needing an emergency admission, is severe enough to require confinement as an inpatient in a hospital within 2 weeks from the date the need for the confinement becomes apparent.

Urgent Care Provider

- A freestanding medical facility which:
 - Provides unscheduled medical services to treat an urgent condition if the person's physician is not reasonably available.
 - Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
 - Makes charges.
 - Is licensed and certified as required by any state or federal law or regulation.
 - Keeps a medical record on each patient.
 - Provides an ongoing quality assurance program. This includes reviews by physicians other than those who own or direct the facility.
 - Is run by a staff of physicians. At least one physician must be on call at all times.
 - Has a full-time administrator who is a licensed physician.
 - It is not the emergency room or outpatient department of a hospital.

or

- A physician's office, but only one that:
 - has contracted with Aetna to provide urgent care; and
 - is, with Aetna's consent, included in the Directory as a Preferred Urgent Care Provider.

Urgent Condition. This means a sudden illness, injury or condition; that:

- is severe enough to require prompt medical attention to avoid serious deterioration of the covered person's health;
- includes a condition which would subject the covered person to severe pain that could not be adequately managed without urgent care or treatment;
- does not require the level of care provided in the emergency room of a hospital; and
- requires immediate outpatient medical care that cannot be postponed until the covered person's physician becomes reasonably available.

Dental Plan

The Dental Plan is administered by MetLife. Under the Dental Plan you have two levels of benefits. You may use a network provider, (referred to as using the “in-network” benefit). Alternately, you may choose to see a provider not affiliated with the network (referred to as using the “out-of-network” benefit). You always have the choice to go in- or out-of-network while you are enrolled in the Plan.

This section of the Summary Plan Description contains a detailed description of the Dental Plan.

Eligibility and Enrollment - Dental Plan

If you are a U.S. benefits-eligible employee (see “Who Is Eligible for These Benefits”), coverage is available for you and your eligible dependents in the Dental Plan on the first day of employment provided you enroll within 31 days of hire.

An hourly employee whose status changes to U.S. benefits-eligible is eligible for coverage as of the date of the status change, provided you enroll within 31 days after the date the status change becomes effective.

Please note that you must be enrolled in the Dental Plan to enroll your dependent(s).

Late Enrollment/Open Enrollment

Enrollment in the Dental Plan is not automatic. Employees who do not enroll within 31 days of becoming eligible will not be eligible to enroll until the next annual Open Enrollment period (usually from mid-October through mid-November), with an effective date for coverage the following January 1.

Cost of Coverage

Pre-tax Monthly Employee Contributions

While the Firm pays most of the cost of coverage, you will be asked to pay a portion of the expense. Your monthly contribution, paid on a pre-tax basis, is determined by the type of coverage you choose. The following are the monthly pre-tax employee contributions for coverage under the Dental Plan:

Type of Coverage	Monthly Employee Contribution
Employee Only	\$8
Employee Plus One Dependent Only	\$16
Employee Plus Two or More Dependents	\$24

The “employee plus one dependent” category is offered because an employees may want to cover only a spouse or a child. If you initially elect to cover yourself and one (1) dependent, you must designate the dependent that will be covered and you may not substitute a different dependent at a later point during the year. If you choose “family” coverage, there is no limit to the number of dependents that can be covered, but all dependent must be enrolled during the Open Enrollment period or within 31 days of your date of hire or a qualified family status change.

Calendar Year Deductibles (Out-of-Network Only)

Other than diagnostic and preventive services, all services that are provided by a dentist or specialist who is not in the MetLife network are subject to a calendar year deductible. The deductible is \$50 per person. To help limit the number of deductibles you need to pay in any year, the Dental Plan has a family maximum deductible. Once any three (3) family members have each satisfied their \$50 deductible, no further deductibles need to be met for covered family members.

Plan Benefits

In-Network Benefits

Network Providers

In order to receive the more generous in-network benefits, you must use dentists and dental specialists who participate in the MetLife network. When services are provided by a member of the MetLife network, you do not have to meet a deductible or file any claim forms. The dentist or specialist will file the claim for you and will collect your portion of the cost at the time services are rendered.

You can find network providers listed on MetLife's Web site, www.metlife.com/mybenefits. As a cost-saving measure, paper copies of the provider directories are not being provided. However, if you do not have access to the Internet you can call the Member Services line 800-942-0854 for a list of providers near you.

Diagnostic and Preventive Care

Under the Dental Plan, diagnostic and preventive dental care is covered at 100% when services are provided by a member of the MetLife network. Diagnostic and preventive care includes:

- Routine examinations - 2 per year
- X-rays: full x-rays every 60 months
- Bitewing x-rays: once per year for adults; twice per year for children
- Cleaning/scaling/polishing: 2 per calendar year
- Fluoride treatment (dependent children under age 19 only) – 1 per year
- Sealants on permanent molar teeth (to age 19 only) – one application every 60 months
- Emergency treatment of tooth pain

Restorative Services

Restorative services are reimbursed by the plan at 80%, when those services are provided by an in-network dentist or specialist. Restorative services include:

- Office visit consultations – 2 per year
- Fillings
- Extractions
- Root canal therapy – once per tooth in a 24 month period
- Periodontics and periodontal Treatment
- Oral surgery
- Relines and rebases to dentures – 1 per 36 months
- General anesthesia

- Space maintainers (to age 19 only)

Prosthodontic Services

Prosthodontic services are reimbursed by the plan at 60%, when those services are provided by an in-network dentist or specialist. Prosthodontic services include:

- Bridgework
- Dentures
- Crowns
- Inlays and onlays
- Implants

Orthodontics

Orthodontic services are reimbursed by the plan at 60% when those services are provided by an in-network orthodontist.

In-Network Maximums

For all in-network procedures, except orthodontics, you and each covered dependent can receive up to \$2,500 in benefits each calendar year.

There is a separate lifetime maximum of \$3,000 for in-network orthodontic care for each covered individual.

Out-of-Network Benefits

Reasonable and Customary Expenses

Out-of-network benefits are reimbursed at a percentage of “reasonable and customary” expenses. The reasonable and customary charge for a service or supply is the lower of:

- The provider’s usual charge for furnishing it; or
- The charge MetLife determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In determining the reasonable and customary charge for a service or supply that is unusual or not often provided in your area, or provided by only a small number of providers in your area, MetLife may take into account factors such as: complexity of the procedure, degree of skill needed, type of specialty of the provider, range of services or supplies provided by a facility and the prevailing charge in other areas.

Pretreatment Review

In order to determine how much the Plan will reimburse, your out-of-network dentist or specialist should submit a pretreatment request to MetLife prior to performing any services.

Diagnostic and Preventive Care

Under the Dental Plan, diagnostic and preventive dental care is covered at 80% when services are provided by a dentist or specialist who is not in the MetLife network. Diagnostic and preventive services are not subject to the annual deductible and include the following:

- Routine examinations - 2 per year
- X-rays: full x-rays every 60 months
- Bitewing x-rays: once per year for adults; twice per year for children
- Cleanings: 2 per calendar year
- Fluoride treatment (dependent children under age 19 only) – 1 per year
- Sealants on permanent molar teeth (to age 19 only) – one application every 60 months
- Emergency treatment of tooth pain

Restorative Services

Restorative services are reimbursed by the plan at 60%, when those services are provided by a dentist or specialist who is not in the Dental Plan network. Restorative services include:

- Office visit consultations – 2 per year
- Fillings
- Routine/surgical extractions
- Root canal therapy – once per tooth in a 24 month period
- Periodontics and periodontal Treatment
- Oral surgery
- Relines and rebases to dentures – 1 per 36 months
- General anesthesia
- Space maintainers (to age 19 only)

Prosthodontic Services

Prosthodontic services are reimbursed by the plan at 50%, when those services are provided by an in-network dentist or specialist. Prosthodontic services include:

- Bridgework
- Dentures
- Crowns
- Inlays and onlays
- Implants

Orthodontics

Orthodontic services are reimbursed by the plan at 50% when those services are provided by an orthodontist who is not in the Dental Plan network.

Out-of-Network Maximums

For all out-of-network procedures, except orthodontics, you and each covered dependent can receive up to \$1,500 in benefits each calendar year.

There is a separate lifetime maximum of \$2,000 for out-of-network orthodontic care for each covered individual.

Exclusions and Limitations

Reasonable and Customary Limits

Out-of-network expenses in excess of the reasonable and customary limits, as defined in “Plan Benefits”, are not covered under the Dental Plan. The following example demonstrates how reasonable and customary limits are applied.

Example of Reasonable and Customary Limit

- Your out-of-network dentist charges \$300 for a specific restorative procedure.
- MetLife determines that the reasonable and customary limit for that procedure is \$200.
- The difference (\$100) is not a covered expense under the Plan; it is not reimbursable and does not count toward your deductible.
- The reasonable and customary portion of the expense (\$200) is a covered out-of-network expense, reimbursable at 60% (\$120) after you have met any required deductible.

Replacement/Addition to Bridgework/Dentures

The replacement of or addition to existing dentures or bridgework is not covered under the Dental Plan. This exclusion will not apply if MetLife is furnished proof that:

The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. The patient must have been covered under a Lehman Brothers dental plan when the teeth were extracted.

The existing denture or bridgework is at least five (5) years old and cannot be made serviceable.

The denture being replaced is an “immediate” temporary one (not a replacement for a prior temporary) and cannot be made permanent. Replacement by a permanent denture is needed and takes place within 12 months of the initial installment of the immediate temporary one.

TMJ Treatment

Dental services for Temporomandibular Joint Syndrome (TMJ) are not covered under the Dental Plan.

Services and supplies primarily or exclusively used to permanently alter occlusion and/or reposition the lower jaw, including appliances or orthodontic banding and wiring and myofunctional therapy, are considered orthodontic in nature.

Experimental Services and Supplies

The Dental Plan does not cover any drug, device, procedure or treatment if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
- If required by the FDA, approval has not been granted for marketing; or

- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes; or
- The written protocol or protocols used by the treating facility or the protocol or protocols of any other facility studying the same drug, device, procedure or treatment states that it is experimental, investigational or for research purposes.

Services Not Performed by a Dentist

Except for the three (3) procedures listed below, the Dental Plan will not provide coverage for any services not rendered by your attending dentist or physician. Services rendered in a hospital by either a resident physician or an intern are not covered under the plan.

The following three (3) procedures are covered expenses when performed by a licensed dental hygienist under the supervision of a dentist:

- Cleaning of teeth;
- Scaling of teeth; and
- Topical application of fluoride.

Cosmetic Services

Services and supplies that are, in whole or in part, cosmetic in nature are not covered under the Dental Plan. This includes teeth whitening and the personalization or characterization of dentures.

Plastic surgery, reconstructive surgery, cosmetic surgery or other services and supplies that improve, alter or enhance appearance, whether or not for psychological or emotional reasons, are not covered under the plan, except to the extent needed to repair an injury that occurs while you are covered under the Lehman Brothers dental plan. To be covered, the surgery must be performed by the end of the calendar year following the calendar year in which the accident occurred.

Other Exclusions

- Initial installation of a denture or fixed bridgework to replace congenitally missing teeth or to replace teeth lost while the patient was not covered under a Lehman Brothers dental plan. This includes inlays and crowns as abutments.
- Services provided and procedures performed before coverage begins or after it ends.
- Charges for failure to keep a scheduled appointment.
- Replacement of a lost, missing or stolen crown, bridge, denture or other dental appliance.
- Expenses that are covered by employer liability laws, workers' compensation or occupational disease laws, or under "no-fault" auto insurance law.
- Services paid for, or for which benefits are provided or required, by reasons of your past or present service in the armed forces of a government.
- Repair or replacement of an orthodontic appliance
- Services or supplies for which no charge would have been made in the absence of Dental Benefits
- Services or supplies for which a Covered Person is not required to pay
- Adjustment of a denture or a bridgework which is made within 6 months after installation by the same dentist who installed it
- Any duplicate appliance or prosthetic device
- Use of material or home health aids to prevent decay, such as toothpaste or fluoride gels, other than the topical application of fluoride provided in a dental office

- Instruction for oral care such as hygiene or diet
- Periodontal splinting
- Temporary or provisional restorations or appliances
- Initial installation of a denture or bridgework to replace one or more natural teeth lost before Dental Expense Benefits started or as a replacement for congenitally missing natural teeth
- Charges by the Dentist for completing dental forms
- Sterilization supplies or charges
- Services or supplies furnished by a family member
- Services or supplies received before dental expense benefits start for that person
- Services or supplies received through a medical department or similar facility which is maintained by the Covered Person's employer
- Services or supplies to the extent that benefits are otherwise provided under the plan or under any other plan which the Employer contributes to or sponsors

How to Submit Your Dental Claims

The following procedures are applicable only to out-of-network claims under the Dental Plan. In-network claims will be filed for you by your dental care provider.

Even if you already submitted a pretreatment estimate form, you still need to submit a claim form for the work done, after it has been completed.

1. Please do not submit any claims to MetLife until you have bills which exceed your annual deductible.
2. Claims should be filed in the same calendar year in which you incur the expenses. Claims must be filed within two (2) years of the date of service or they will not be eligible for reimbursement.
3. Please use the proper claim form. Complete a MetLife Dental Benefits Request form ("claim form") for each claim that you file. MetLife will not process claims submitted without a Dental Benefits Request form. The address you list on the claim form is the address used for any reimbursement due you.
4. Always include your (the employee's) Social Security number. It serves as the identification number for you and your covered dependents. Without it, MetLife cannot process claims for you or any of your covered dependents.
5. Attach complete, itemized bills to your claim form. Itemized bills should include the following information:
 - Dentist's name and tax identification number;
 - Employee's name;
 - Employee's Social Security number;
 - Patient's name;
 - Date of service or purchase;
 - Condition being treated or diagnosis; and
 - The charge for each service or supply.
6. Send only original bills, not photocopies. Keep copies of all bills and claim forms for your own files.
7. Send all dental claims and itemized bills to: MetLife Dental, P.O. Box 981282, El Paso, TX 79998-1282.

Vision Care Plan

The Vision Care Plan (the “Plan”) is designed to assist you with the purchase of routine vision products and services for you and/or your dependents. The Plan is administered by Davis Vision, which currently has over 10,000 providers nationally in its Vision Care network. When you use Davis Vision providers and materials, there is virtually no out-of-pocket cost to you (see “In-Network Benefits” for details).

There are very limited out-of-network benefits. If covered individuals do not use the Davis Vision providers, the Plan provides only a small, fixed reimbursement (see “Out-of-Network Benefits” for details).

Highlights of the Vision Care Plan

The following pages contain a detailed description of the Vision Care Plan. Below is a list of some of the highlights of the Plan’s provisions:

- Comprehensive eye examination from a Davis Vision network provider every calendar year, with no copayment.
- Choose from any one of Davis Vision’s 300 name-brand and designer frames every calendar year, with no copayment.
- Virtually any type of eyeglass lenses available every calendar year, most with no copayment.
- Generous discounts if you wish to purchase eyeglass frames or contact lenses that are not covered under the Plan, or if you purchase a second pair of eyeglasses.
- If you use the Davis Vision provider network, you do not need to file any claim forms.

Eligibility and Enrollment

If you are a U.S. benefits-eligible employee (see “Who is Eligible for These Benefits” coverage for you and/or your eligible dependents in the Vision Care Plan is available on the first day of employment provided you enroll within 31 days of hire.

Hourly employees whose status changes to U.S. benefits-eligible are eligible for coverage as of the date of their status change, provided they enroll within 31 days after the status change becomes effective.

Under the Vision Care Plan, you do not have to be enrolled to cover your dependent(s). For example, you may choose to waive coverage for yourself, but enroll your spouse in the Vision Care Plan. Your monthly employee contributions for participation in the Vision Care Plan are based on the number of individuals you wish to cover (see “Cost of Coverage”).

Late Enrollment/Open Enrollment

Enrollment in the Vision Care Plan is not automatic. Employees and/or eligible dependents who do not enroll within 31 days of becoming eligible will not be eligible to enroll until the next annual Open Enrollment period (usually from mid-October through mid-November) with an effective date for coverage the following January 1.

Making Changes to Vision Coverage

Because your employee contributions are made on a pre-tax basis, the Internal Revenue Service requires that your election stay in effect throughout the full Plan Year. Once you make an election, you cannot change your election during the year unless you undergo what the IRS calls a “qualified family status change.” The “Qualified Family Status Changes” table lists the events that qualify and which documentation is required.

Cost of Coverage

Your monthly premium, paid on a pre-tax basis, is determined by the number of individuals covered. You yourself do not have to be enrolled to cover a dependent or spouse. See the chart below for the monthly pre-tax employee contributions for coverage under the Vision Care Plan.

Vision Care Plan Monthly Employee contributions

Coverage Level	Monthly Pre-Tax Employee Contribution
One (1) Family Member	\$8.33
Two (2) Family Members	15.02
Three (3) or More Family Members	22.51

You must designate the covered individuals and you may not substitute a different individual at a later point during the year. If you choose to cover “Three or More Family Members”, there is no limit to the number of individuals that can be covered, but they all must be enrolled during the Open Enrollment period or within 31 days of your date of hire or a qualified family status change.

Plan Benefits/Covered Expenses

Davis Vision Providers

Network providers are listed in the Davis Vision provider directory. For a list of providers near you, access the Davis Vision Web site at www.davisvision.com to find a network provider near you.

There are two types of network providers:

“Tower” Provider: In addition to performing examinations and providing prescriptions, these providers have the Davis Vision Premier Collection of frames, which are covered under the Plan with no copayment. Davis Vision supplies a display rack to providers, which is often referred to as the “Davis Vision Tower.” There are approximately 300 name-brand and designer frames on the Tower.

“Examination-Only” Provider: These providers can perform examinations and provide prescriptions. However, frames and lenses will have to be selected at another provider location.

In-Network Benefits

You are entitled to a comprehensive eye examination every calendar year. When the exam is performed by a Davis Vision participating provider, there is no copayment required.

Every 12 months you are entitled to new eyeglass frames. When you choose from the Davis Vision Premier Collection, there is no copayment required for the frames.

If you choose to purchase non-"Tower" frames from your Davis Vision provider, you can do so at a significant discount, calculated as follows: Wholesale cost of frames, minus \$50, times 2 = your cost. *For example:* A brand-name frame that retails for \$329 may have a wholesale cost of \$90. Your cost would be calculated as (\$90 - \$50) x 2, for a total out-of-pocket cost to you of \$80.

If you purchase a second pair of glasses from your Davis Vision provider, you are eligible for a 20% discount on any frames.

In addition, you are entitled to an annual (every 12 months) selection of eyeglass lenses or contact lenses as noted below:

Eyeglass Lenses

The following lens features are available with no copayment:

- Plastic or glass lenses, in any prescription range, including single vision, bifocal and trifocal lenses;
- Fashion, sun or gradient-tinted plastic lenses;
- Polycarbonate lenses;
- Blended invisible bifocal lenses;
- Glass grey #3 prescription lenses;
- Oversize lenses;
- Post-cataract (lenticular) lenses;
- Ultraviolet (UV) protective lens coating;
- SuperShield® (scratch-protective) lens coating; and
- Photogrey Extra® (sun-sensitive glass) lenses.

The following lens features are available with an additional copayment.

Special Feature	Copay
Polarized Lenses	\$ 75
Anti-Reflective Coating	
• Standard	35
• Premium (Crizal)	48
Plastic Photosensitive Lenses (Transitions®), Single Vision or Multifocal	65
High Index Lenses	55
Progressive Addition Lenses (PALS)-	
• Standard types	0
• Premium types (Kodak®, Varilux®,etc	40
Intermediate Vision Lenses	30

Note: Davis Vision provides a one-year unconditional breakage warranty for all eyeglasses (frames and lenses) that are fully supplied by Davis Vision.

Contact Lenses

In lieu of eyeglass lenses, every calendar year, the Plan provides a \$175 credit which can be used toward the purchase of contact lenses, fitting fees and follow-up care. You are responsible for any cost in excess of the \$175 credit.

The \$175 credit is applicable to any type of contact lenses in your provider's selection, including toric or gas permeable lenses.

A mail order replacement contact lens service, Lens 1-2-3®, is also available. For more information, including costs, please call Lens 1-2-3® at 800-536-7123.

Out-of-Network Benefits

There is limited coverage for services and supplies furnished by non-network providers.

If you use non-Davis Vision provider, you are eligible for out-of-network reimbursement based on the following schedule:

- Exam: up to \$30.
- Lenses: Up to \$25 for single vision correction, up to \$35 for bifocal, up to \$45 for trifocal, up to \$60 for leticular.
- Eyeglass frames only: up to \$50.
- Contact lenses: up to \$100.

Expenses Not Covered Under the Vision Care Plan

The following services and supplies are not covered under the Vision Care Plan:

- Medical treatment of eye disease or injury. This is generally covered under most medical plans.
- Visual therapy.
- Special lens designs or coatings, other than those listed in the "In-Network Benefits" section.
- Replacement of lost eyewear.
- Non-prescription lenses.
- Two pairs of eyeglasses in lieu of one pair of bifocals.
- Eyeglasses and contact lenses during the same benefit period.

How to Submit Your Vision Care Claims

In-Network

No claim forms are required for in-network benefits. To access service, please:

1. Call the network doctor of your choice and schedule an appointment. For a copy of the network provider directory for your home or work state, please call Davis Vision at 800- 999-5431. You can also access provider directories on Davis Vision's Web site at www.davisvision.com.
2. Identify yourself as a Lehman Brothers employee or dependent.
3. Give the provider's office staff the employee's Social Security number and the year of birth of any covered dependent needing services.

4. The doctor's office will verify your eligibility in advance.

Out-of-Network

If you purchase eyeglass frames or contact lenses that are not covered under the Plan, or if you go to an out-of-network provider, please:

1. Pay the provider directly for all services and/or products.
2. Submit your paid claims with all itemized bills to: Vision Care Processing Unit, P.O. Box 1525, Latham, NY 12110.

To obtain claim forms, please visit LehmanLive under the Lehman & You page, click on claim forms.

Flexible Spending Accounts

What is a Flexible Spending Account?

A Flexible Spending Account (“FSA”) is an IRS-regulated tax-free account that can save you money on your health care and day care costs. You will not have to pay federal income and Social Security taxes on money you contribute to cover qualifying health care or day care expenses.

All Flexible Spending Account contributions are permanently exempt from federal income and Social Security taxes. In most states, you will not have to pay state taxes either.

How it Benefits You

A Flexible Spending Account may save you money and may be useful in many situations, for instance, if:

- You wear glasses or contacts;
- You regularly meet your medical and/or dental deductibles each year;
- You are planning extensive dental work;
- Your child is in day care; or
- An elderly dependent is receiving home care services.

How it Works

Flexible Spending Accounts are funded by your pre-tax payroll deductions. Your Flexible Spending Account reimburses you for qualified health care and/or day care bills you have paid during the year. There are differences in the way bills are reimbursed depending on which Flexible Spending Account you use, Health Care or Day Care. See the “How to File a Claim” sections for more details.

The “Use It or Lose It” Clause

Under Internal Revenue Service regulations governing Flexible Spending Accounts, you must:

1. Incur all eligible expenses by the Plan year during which your Flexible Spending Account contribution is in effect (generally, the Plan year is the period from the later of January 1st or your hire date through December 31st); and
2. Request reimbursement of those eligible expenses incurred by the deadline that is announced annually, usually in mid-June of the following calendar year.

For example, during the open enrollment period for 2008 an employee elects to contribute \$1,000 to their Health Care Flexible Spending Account. Between January 1st 2008 and December 31st 2008 they will have \$1,000 deducted from their paychecks. This \$1,000 account balance can be used for qualified health care bills the employee incurs between January 1st 2008 and December 31st 2008; provided that the employees requests reimbursement for those expenses by the June 2009 deadline.

If you do not submit your expenses for reimbursement by the deadline, any balance remaining in your account will be forfeited. That is why it is important to plan your contributions carefully.

Forfeited funds are used to defray the administrative costs of the Plan.

Effect of Pre-Tax Contributions on Other Benefits

Contributions to your Flexible Spending Account will not impact your earnings for purposes of calculating pension benefits under the Retirement Plan; contributions under the Lehman Brothers Savings Plan; and earnings for Life and Disability coverage. However, because you are lowering your taxable income for Social Security purposes, your Social Security benefits may be reduced if you contribute large amounts of income to your Flexible Spending Accounts.

Eligibility and Enrollment

Enrollment in the Flexible Spending Accounts is available for U.S. benefits-eligible employees (see the “Who Is Eligible for These Benefits” section) who enroll within 31 days of hire, or during the annual Open Enrollment period. Hourly employees whose status changes to salaried part-time or full-time may enroll within 31 days after their status change takes effect.

There are additional eligibility requirements for the Day Care Spending Account. See the “Eligibility” section of the Day Care Spending Account section for details.

You designate the amount you wish deducted from your paycheck and contributed to each Spending Account. This is called your “election.” The annual amount(s) you specify will be deducted in equal installments from each paycheck and deposited to either or both of the accounts, as you specify. Throughout the year, you can view statements of your account balances directly at www.WageWorks.com.

Late Enrollment/Open Enrollment

Enrollment is not automatic. Eligible employees who do not enroll in an FSA within 31 days of hire will not be eligible to enroll until the next annual Open Enrollment period, usually from mid-October through mid-November.

You may be eligible to enroll in the Day Care Spending Account mid-year, if you experience a qualified family status change. See the “Mid-Year Changes to Your Election” section for details.

How to Enroll

Through e-Benefits, you may enroll in the Flexible Spending Account(s) of your choice (Health Care, Day Care or both).

Health Care Account

Enter your annual payroll deduction through e-Benefits. If you are enrolling during the Open Enrollment period, your annual election will be divided by twelve (rounding up to the nearest whole dollar) and that amount will be your monthly payroll deduction. If you are enrolling as a new hire, the monthly payroll deduction will be calculated based on the number of payrolls remaining in the calendar year, and deductions will begin with your next paycheck.

Day Care Account

Important Note: The Internal Revenue Service sets an annual Day Care election limit of \$5,000 per family. You are responsible for coordinating your annual election with your spouse and/or a prior

employer's Flexible Spending Account. See the "Maximum Contributions" section for further limitations on the Day Care Account.

If you are enrolling during the Open Enrollment period, your annual election will be divided by twelve (rounding up to the nearest whole dollar) and that amount will be your monthly payroll deduction. If you are enrolling as a new hire, the monthly payroll deduction will be calculated based on the number of payrolls remaining in the calendar year, and deductions will begin with your first paycheck.

Note: Remember, your Day Care provider must have a Social Security number or a tax ID number in order for expenses to be eligible for reimbursement.

Eligible Dependents

Health Care Account

You can use your Health Care Account to pay for health care expenses incurred by any of the following people - even if they are not covered by your employer's health plan:

- You
- Your spouse
- Your other dependents, as defined by the Internal Revenue Code

For purposes of your Health Care Account, a person will generally qualify as your dependent if he or she is either your child, brother or sister, grandchildren or niece or nephew and if he or she (i) lives with you for more than one-half of the year; (ii) is either under 19, a student under the age of 24 as of the end of the year, or totally and permanently disabled during the year; AND (iii) has not provided over one-half of his or her own support for the year. Additional close relatives may qualify if he or she lives with you for more than one-half of the year and you provide more than one-half of his or her support for the year.

Child of Divorced or Separated Parents. As long as the parents together provide over half the child's support, the child will be considered a dependent of both parents regardless of who can claim the tax exemption or is treated as the custodial parent.

Dependent Care

You can use your Dependent Care Account to pay for expenses to care for certain dependents. Generally, to be eligible dependents they must live with you for more than one-half of the year and be one of the following:

- Your dependent who is under age 13 when the care is provided if the dependent is your child, brother or sister, niece, nephew, or grandchild and if he or she has not provided over one-half of his or her own support for the year.
- Your spouse who is physically or mentally incapable of caring for himself or herself.
- Your other close relative who is physically or mentally incapable of caring for himself or herself and who lives with you, provided that you provide more than one-half of his or her support for the year and he or she has earned less than the exemption amount (currently \$3,100).

For more information please contact the HR Service Center at 212-526-2363.

Child of Divorced or Separated Parents. If you are the non-custodial parent, you cannot treat your child as an eligible dependent under the Day Care Spending Account even if you can claim the child as an exemption.

If you are the custodial parent, you may be able to treat your child as an eligible dependent even if you cannot claim the child as an exemption.

See IRS Publication 503 for details.

Mid-Year Changes to Your Election

If you experience certain qualified family status changes, you may be able to enroll, increase or decrease* your annual Spending Account election. You may not decrease your annual election below the amount you have contributed as of the date your change request has been received and processed. See the “Mid-Year Changes to Coverage” section for more details. The chart shown below details events that qualify as family status changes and whether you may enroll, increase or decrease your Spending Account annual election as a result.

Note: If you or your spouse stop working, you are no longer eligible to participate in the Day Care Spending Account under IRS guidelines. You should notify the HR Service Center to stop deductions.

Qualified Family Status Change

Qualifying Event	Permitted Change(s) to Day Care Spending Account
Marriage or domestic partnership	Enrollment Increase your election, or Decrease* your election
Divorce, legal separation or termination of domestic partnership	Enrollment Increase your election, or Decrease* your election
Birth or adoption of a child (including initiation of adoption proceedings); legal guardianship of a child	Enrollment Increase your election
Spouse or domestic partner becomes unemployed, loses coverage or takes unpaid leave of absence.	Increase your election
You take unpaid leave of absence	Decrease* your election
Death of spouse or dependent	Decrease* your election
Spouse or domestic partner becomes employed and/or becomes eligible for family coverage	Enrollment Increase your election, or Decrease* your election

When a decrease is allowable, you may decrease your annual election to an amount equal to the amount you have already contributed. This will have the effect of canceling future deductions. Due to IRS regulations, amounts already deducted from your pay cannot be refunded.

Becoming Ineligible for Flexible Spending Accounts

Generally, your eligibility to participate in the Flexible Spending Accounts ends when your employment terminates or you cease to be a U.S. benefits-eligible employee (see the “Who Is Eligible for These Benefits” section).

If your employment terminates during the year, you can continue to participate in your Health Care Flexible Spending Account for the remainder of the plan year through COBRA. See “Continuation Coverage” for details.

If you do not choose to continue to make a contribution on an after-tax basis after termination, the funds remaining in the account can only be used to reimburse you for services incurred prior to your termination date.

You cannot continue to participate in the Dependent Care Flexible Spending Account through COBRA, however, the funds remaining in your account can be used to reimburse you for services incurred through December 31 of the plan year.

Day Care Account Only: Your eligibility for the Day Care Account ends when your covered dependents no longer meet the definition of an eligible dependent, or you and your spouse cease to qualify under IRS guidelines.

If you cease to be eligible for reimbursement from the Day Care Spending Account, you must cancel your deduction through e-Benefits. See the “Mid-Year Changes to Coverage” section for details. Due to IRS regulations, deductions already taken cannot be refunded.

Pre-Tax Savings at-a-Glance

The following examples illustrate some potential savings available by utilizing a Flexible Spending Account. Your actual tax savings may vary based on your personal tax situation. These examples are estimated based on assumed federal income tax and FICA rates. If your contribution is also exempt from state and local taxes, savings may be even greater.

Example #1:

\$50,000 Annual Taxable Income, Single Taxpayer, \$1,200 in Eligible Expenses

	No FSA	With FSA
Gross Income	\$50,000	\$50,000
Minus FSA contributions (\$42 per month)	-	(1,200)
W-2 Income	50,000	48,800
Minus Federal Income Tax*	(12,500)	(12,200)
Minus FICA	(3,825)	(3,733)
Minus After-Tax Health and/or Day Care Expenses	(1,200)	-
Income After Taxes and FSA Eligible Expenses	\$32,475	\$32,867
Federal Tax Savings Attributable to FSA contribution		\$392

* Assumes a 25% tax rate.

This employee has saved \$392 by contributing \$1,200 to a Flexible Spending Account

Example #2:

\$100,000 Annual Taxable Income, Married, Filing Jointly, \$2,600 in Eligible Expenses

	No FSA	With FSA
Gross Income	\$100,000	\$100,000
Minus FSA contributions (\$216.67 per month)	-	(2,600)
W-2 Income	100,000	97,400
Minus Federal Income Tax*	(28,000)	(27,272)
Minus FICA	(7,495)	(7,451)
Minus After-Tax Health and/or Day Care Expenses	(2,600)	-
Income After Taxes and FSA Eligible Expenses	\$61,905	\$62,677
Federal Tax Savings Attributable to FSA contribution		\$772

*Assumes a 28% tax rate.

This employee has saved \$772 by contributing \$2,600 to a Flexible Spending Account.

Health Care Spending Account

Eligible Dependents

For the purposes of the Health Care Spending Account, a dependent is anyone who qualifies as a dependent under your health and/or dental plan, whether they are covered by a plan through Lehman Brothers or not.

Eligible Expenses

To be eligible for reimbursement for the Plan year, expenses must be for services rendered during the Plan year (January 1st, or date of hire if later, through December 31st) and must be paid for while a Health Care Spending Account election is in effect. New hires may not submit expenses that were incurred prior to their date of hire.

In some instances, health care providers will require a prepayment for services to be provided over a period of time (i.e., orthodontia and maternity care). The Health Care Spending Account can only reimburse you for services you actually receive within the Plan year and which are incurred while your election is in effect.

Eligible expenses include:

- Medical plan deductibles, copayments and coinsurance which are not covered under another medical plan or insurance. You must have receipts from your health care providers. *For example:* the 10% of costs you are required to pay as coinsurance under the terms of the medical plan or the copayment charged by the doctor for any office visit under the medical plan.
- Dental care: expenses not covered by any dental insurance or amounts in excess of any dental plan payment or annual maximum.

- Medical expenses to the extent not covered by any insurance plan, such as:
 - Acupuncture³
 - Prescription vitamin supplements, when prescribed for a medical condition;
 - A private hospital room
 - Vision testing, eyeglasses and contact lenses⁴

Some non-prescription medical equipment may be eligible for reimbursement with documentation of medical necessity. Contact WageWorks at 877-924-3967 to verify the expense before submitting a reimbursement request.

Expenses Not Covered

- Insurance premiums or payroll deductions paid by you, a spouse or a dependent. This includes COBRA payments.
- Expenses that are not considered deductible medical expenses by the IRS, such as cosmetic surgery.
- Expenses eligible for full reimbursement under any medical or dental plan (or a combination of plans) in which you or your dependents participate.
- Athletic club expenses, exercise equipment, hot tubs, whirlpool baths and swimming pools.
- Contact lens insurance.
- Non-prescription vitamins and natural foods.
- Your divorced spouse's medical bills or COBRA payments.

Election Maximum

You may fund a Health Care Spending Account for any amount from \$120 to \$5,000 per year (\$10 to \$417 per month) and use it to reimburse expenses incurred during the Plan year.

Restrictions

You may not claim a federal income tax deduction for any amount that has been reimbursed by a Flexible Spending Account. The IRS requires, as part of the Health Care Spending Account claim form, that you sign a document stating that the expenses submitted under the Health Care Spending Account are not eligible for reimbursement under any other plan.

How to Access Your Health Care Spending Account

Under the Health Care Spending Account, your total annual election is available for reimbursement on the first day of the plan year (or the first day of enrollment, if you are a new hire). You may request reimbursement for eligible expenses for any amount up to your total annual election, even if that amount has not yet been deducted from your pay.

³ These expenses may be covered, or partially covered, by your medical plan.

⁴ If you are enrolled in the Vision Care Plan, your copayments and any out-of-pocket vision care expenses are eligible for reimbursement from the Health Care Spending Account.

For example, you enrolled for an annual election of \$1,200 (\$100 per month) for plan year 2008. In February, you incur eligible expenses of \$1,200 or more. You may request reimbursement of the entire amount in February, even though only \$200 has been deducted from your pay. Payroll deductions will continue for the rest of the plan year.

There are 3 methods of accessing the funds in your account. You can use the WageWorks Health Care Card, have WageWorks mail a check directly to your provider through Pay My Provider, or you can submit a claim form through Pay Me Back.

The WageWorks Health Care Card

When you enroll in the Health Care Spending Account you will receive a WageWorks Health Care Card. The card works like a credit card that you can use to purchase eligible health care services and items at qualified merchants who accept MasterCard. The costs associated with all eligible transactions will be automatically deducted from your Health Care Spending Account. The card can be used to pay for co-payments, deductibles, prescriptions purchased at a pharmacy or through mail order, or prescription eyeglasses. Please be sure to keep your receipts and other records each time you use the card. In most cases WageWorks receives enough information about your purchase when you pay with the card to confirm that it was for an eligible expense. Occasionally WageWorks may require you to submit a receipt to verify the eligibility of an expense.

If you cannot show the card was used to pay for an eligible expense then you will be required to reimburse your Health Care Account for the amount of the purchase. If you do not reimburse your account, the amount due will be deducted from any future reimbursement checks.

If you misuse your card, such as charging ineligible expenses and not reimbursing your account upon request or regularly charging ineligible expenses, Lehman may suspend your card privileges for the current or future years and also may take additional disciplinary action. In addition to any disciplinary action taken, any unsubstantiated amounts that are not reimbursed will be considered taxable income to the employee, subject to withholding and inclusion on the your Form W-2.

Pay My Provider

You can instruct WageWorks to pay your provider directly through the Request Pay My Provider section under Health Care on WageWorks' website. WageWorks will write and mail a check directly from your account. This payment option is convenient if you have regularly scheduled payments for eligible expenses such as physical therapy, or when you are billed for expenses not covered by insurance by your provider. The minimum Pay My Provider amount is \$20.00.

Pay Me Back

You may submit a claim form to WageWorks and receive a reimbursement check in those cases where a provider does not accept credit cards, you are purchasing over-the-counter medications and need to submit a receipt or under other circumstances where you pay in advance. To receive a reimbursement check, complete a Pay Me Back Health Care Account Claim Form. Attach detailed, itemized bills to all claim forms.

You will have until mid-June of the following calendar year to submit claims for reimbursement of covered expenses incurred during the Plan year. No claims for covered expenses received after June of the following year will be accepted.

Forfeiture of Unused Amounts

Any funds not used during the calendar year for which they were designated will be forfeited in accordance with current IRS regulations.

How to Plan Your Health Care Spending Account Election

The online Health Care Spending Account Worksheet can help you estimate how much you might contribute to a Health Care Spending Account for the Plan year:

- Minimum annual contribution: \$120 (\$10 per month)
- Maximum annual contribution: \$5,000 (\$417 per month)

Estimate expenses you expect to incur between January 1st (or your date of hire, if later) and December 31st of the calendar year only. Expenses incurred before the calendar year or the year following the applicable calendar year will not be eligible for reimbursement from the Health Care Spending Account for that calendar year.

Day Care Spending Accounts

Eligibility

A Day Care Spending Account is for married working couples or single working people with eligible dependents (see the “Eligible Dependents” section). You may participate if you (or you and your spouse, if you are married) have dependents who require day care in order to allow you (or you and your spouse, if you are married) to work, or for your spouse to attend school.

If you do not currently have an eligible dependent, you may not enroll in the Day Care Spending Account at this time, even if you are planning to have or adopt a child during the calendar year. For example, if you are hired in February, and you expect to become a parent in June, you may not enroll in the Day Care Spending Account immediately. Once the child is born (or placed with you for adoption), you have 31 days in which you may enroll in the Day Care Spending Account for the remainder of the calendar year.

Maximum Contributions

You may fund a Day Care Spending Account for any amount from \$120 to \$5,000 per year (\$10 to \$417 per month) and use it for reimbursement for the expense of caring for your eligible dependents while you work. This account can be used to reimburse expenses for home child care, day care center costs, etc. (see the “Eligible Expenses” section), but not for the dependent’s medical expenses.

If you are married, the amount of expenses for which you can be reimbursed may not exceed the lesser of your earned income or your spouse’s earned income for the year. If your spouse is a full-time student, or is physically or mentally incapable of self-support, the IRS deems your spouse to have earned income of \$200 per month. If this is the case, the maximum you may contribute to your Day Care Spending Account is \$2,400 (\$200 per month, \$400 for 2 or more eligible dependents).

The IRS limits the amount of tax-free dollars each family can deposit in a Day Care Spending Account. If both you and your spouse elect to fund a Day Care Spending Account, your combined elections cannot exceed \$5,000 (\$417 per month). If you are married and filing separate tax returns, you and your spouse are each limited to a maximum election of \$2,500.

If you are a new hire, and you participated in a Day Care Spending Account through your prior employer, you are responsible for coordinating your annual election between the two accounts.

Federal Tax Credit

For some people, the federal tax credit would result in a greater savings than using a Day Care Spending Account. It is best to consult your personal tax advisor if you are unsure which method would be best for you.

The federal tax credit is a percentage of eligible work-related expenses, such as the ones described in the “Eligible Expenses” section below. When calculating the federal tax credit on your income tax return, you must reduce your eligible work-related expenses, dollar-for-dollar, by any amounts excluded from income under the Day Care Spending Account. *For example*, if you qualify for a federal tax credit based on \$2,400 of eligible work-related expenses, and you funded a Day Care Spending Account of \$1,000, your federal tax credit is based on eligible work-related expenses of \$1,400.

Your Form W-2

Contributions to the Day Care Spending Account will appear in Box 10 on your Form W-2. While not included in taxable income, the amount shown in Box 10 will alert the IRS to your participation in this account.

Provider Identification

Any taxpayer claiming Day Care credit or excluding Day Care reimbursement from income must provide the name, address and taxpayer identification number or Social Security number of the dependent day care provider.

Eligible Expenses

To be eligible for reimbursement for the Plan year, expenses must be for services rendered and paid for:

1. Between January 1 and December 31 of the Plan year; and
2. While a Day Care Spending Account election is in effect. New hires may not submit expenses that were incurred before their date of hire.

In some instances, Day Care providers will require a prepayment for services to be provided over a period of time (e.g. 6 months in advance). The Day Care Spending Account can only reimburse you for services you actually receive within the Plan year and which are incurred while your election is in effect.

In addition, eligible Day Care services must have been incurred to enable you, if you are single, or you and your spouse, if you are married, to remain gainfully employed during a period in which there was at least one (1) eligible dependent residing in your household.

If you are married, you will be eligible for reimbursement of dependent day care expenses for your eligible dependent(s) only if your spouse is also employed, or if he or she is a full-time student.

Specific expenses eligible for reimbursement might include the following:

- Preschools, day care or elder care centers.
- Non-educational programs for children up to age 13 while schools are not in session (including summer day camp, but not including overnight camp).

- The cost for an individual to care for your children under age 13 inside or outside your home.
- Home care, non-medical nursing or nurse's aide services for a dependent parent who lives with you.
- Special non-medical care for mentally or physically handicapped dependents.
- FICA and FUTA taxes on wages paid to a dependent day care provider. If you use the services of a "Day Care center," the center must meet all requirements of state and local law. A "Day Care center" means any facility which provides care for more than six (6) individuals (other than individuals who reside there) and receives payment or grants for providing Day Care services.

Expenses Not Covered

You cannot be reimbursed for expenses incurred for the following:

- A dependent who is not an eligible dependent as defined in the "Eligible Dependents" section above.
- Baby-sitting during non-working hours (e.g., "Saturday night" baby-sitting).
- Payments to a dependent whom you or your spouse are entitled to claim as a dependent on your federal income tax return, such as an older child under age 19 who cares for a younger brother or sister.
- Food, clothing, education or transportation between your home and the Day Care facility.
- Nursing home meals and lodging.
- "Sleep-away" camp.
- Instructional services such as tennis or music lessons.

In addition, the Day Care Spending Account cannot reimburse expenses for out-of-home care of a dependent unless the dependent returns to the employee's home at night to sleep. You may not claim dependent day care expenses that exceed the lesser of:

- Your fixed dollar maximum under the Day Care Spending Account (see the "Maximum Contributions" section above);
- Your earned income; or
- You are married, your spouse's earned income.

How to Access Your Day Care Spending Account

You cannot be reimbursed for any amount unless that amount has already been deducted from your pay. For example, you enrolled for an annual election of \$2,400 (\$200 per month). In February, you incur reimbursable expenses in the amount of \$2,400. The most you can be reimbursed in February is \$400, the amount that has been deducted from your pay.

There are 2 methods of accessing the funds in your account. You can have WageWorks send a check directly to your provider through Pay My Provider, or you can submit a claim form through Pay Me Back.

Pay My Provider

You can instruct WageWorks to pay your provider directly through the Request Pay My Provider section under Dependent Care on the WageWorks Web site. WageWorks will write and mail a check directly from your account in the amount requested or your account balance before the payment date, whichever is lower.

Pay Me Back

You may submit a claim form to WageWorks and receive a reimbursement check. To receive a reimbursement check, complete a Pay Me Back Dependent Care Account Claim Form. Attach detailed, itemized bills to all claim forms.

The IRS requires, as part of the Day Care Spending Account Reimbursement Request form, that you sign a document stating that the expenses submitted under the Day Care Spending Account are not eligible for reimbursement under any other plan. The form also requires the caregiver's tax identification number (i.e., Social Security number or employer identification number).

How to Plan Your Day Care Spending Account Election

The online Day Care Spending Account Worksheet will help you estimate how much you might contribute to a Day Care Spending Account:

- Minimum annual contribution: \$120 (\$10 per month)
- Maximum annual contribution: \$5,000 (\$417 per month)

Estimate expenses you expect to incur between January 1 (or your date of hire, if later) and December 31 of the calendar year only. Expenses incurred before or after the calendar year will not be eligible for reimbursement from the Day Care Spending Account for that calendar year.

COBRA

Continuation Coverage

As part of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), you and/or your eligible dependents who lose coverage under any of the Firm-sponsored health care plans (the Medical, Dental or Vision Care Plans and the Health Care Spending Account) as a result of the circumstances described in the chart below (called qualifying events) can continue coverage through the Firm at your (or your dependents') own expense. Of course, if you (or your dependents) are not covered under one or more of these plans, you (or they) are not eligible for continuation of coverage. If you (or your dependents) are eligible for Medicare benefits, you (or your dependents) are not eligible for continuation coverage under COBRA. You may, however, elect conversion (see the "Conversion Privilege" section for details).

Qualifying Event	Maximum Coverage Period
Reduced work hours	18 months
Resignation or employment termination (unless for gross misconduct)	18 months
Dependents of resigned or terminated employees	18 months
Employee's death	36 months
Divorce or legal separation	36 months
Dependent child whose eligibility ends (for example, exceeds Plan's age limit, is no longer a full-time student, gets married or becomes a full-time employee)	36 months
Employee or dependent who is disabled within 60 days of the qualifying event	29 months

Termination of Plan

Continuation coverage is not available if the Plan is terminated by the Firm.

COBRA Notification

Upon termination of your employment with Lehman Brothers, a COBRA notice and information package will automatically be sent to your home address on file.

Under COBRA, you (or your dependent) have the responsibility to inform the HR Service Center of a qualifying event, such as divorce, legal separation or a child's loss of dependent status within 60 days of the qualifying event. When the HR Service Center is notified, it will in turn notify you (or your dependent) of your (or your dependent's) right to choose continuation coverage.

You have 60 days from the date the COBRA notice is sent to you to select continuation coverage. If you choose continuation coverage, you will have 45 days from the date of your election to pay the first premium.

Payment for COBRA

COBRA requires you and your dependents to pay premiums promptly for continuation coverage. You will be notified by the Firm, or the claims administrator, of the amount of your premium (which includes the employee and employer costs, plus an administrative charge permitted by law).

For COBRA rates, contact the HR Service Center at 5-2363 (212-526-2363).

You (or your eligible dependents) have 60 days from the COBRA eligibility notice date to apply for continuation coverage, and your coverage will be retroactively reinstated to the date coverage terminated. Your first premium payment must be made within 45 days of the election of COBRA coverage. Thereafter, you will be billed monthly. Payment must be made within 31 days of the due date. If your payment is not received within 31 days of the due date, your COBRA coverage will be terminated retroactive to the first day of the month for which the premium has not been paid. Once terminated, your coverage cannot be reinstated.

Health Care Spending Accounts

If your employment terminates during the year, you are permitted to continue making contributions to your Health Care Spending Account on an after-tax basis for the remaining calendar year only.

If you do not choose to continue making contributions on an after-tax basis after termination, the funds remaining in the account can only be used to reimburse you for services incurred prior to your termination date.

When Continuation Coverage Ends

Within the 18-month, 29-month, or 36-month continuation period, coverage for the applicable beneficiary will be terminated upon:

- Failure to make the necessary payments promptly.
- New coverage under another group health plan.
- Ceasing to be disabled (if COBRA coverage is being provided for a 29-month period based on disability).
- The Firm no longer provides group health coverage to any of its employees. (Coverage is subject to change at any time without prior notice or consent.)

If the new plan contains a pre-existing condition clause which affects the COBRA recipient, that person may continue COBRA coverage for the period of time designated by the pre-existing condition clause.

Conversion Privilege

At the time of termination of group coverage under the Aetna Choice POS II option of the Lehman Brothers Inc. Medical Plan, or upon expiration of the maximum term of continuation of coverage (18 months, 29 months, 36 months, or eligibility for Medicare), conversion to an individual basic medical policy (with very limited coverage) will be offered at the individual's expense. Individuals who terminate their Aetna Choice POS II COBRA coverage prior to the end of the 18-month, 29-month or 36-month continuation period will not be offered an individual policy.

Group Term Life Insurance

The following section discusses the Basic and Supplemental Term Life Program which is available to all new hires and to employees who earn less than \$200,000 per year. For those employees who earn \$200,000 per year or more, please see the “Group Variable Universal Life” section.

The **Group Term Life Insurance Plan** (“the Plan”) is a fully-insured life insurance plan insured by MetLife. Coverage for eligible participants is based on Insurance Earnings (see the “Definition of Insurance Earnings” section), as follows:

- **Basic Term Life Insurance:** An automatic, Firm-paid benefit providing term life coverage in the amount of one (1) times Insurance Earnings to a maximum of \$100,000 of coverage.
- **Accidental Death and Dismemberment Insurance:** An automatic, Firm-paid benefit providing accidental coverage in the amount of one-half of Basic Life Insurance to a maximum of \$50,000 of coverage.
- **Supplemental Term Life Insurance:** An elective, employee-paid benefit providing term life coverage of one (1) to nine (9) times Insurance Earnings to a maximum of \$1,900,000 of coverage. To elect coverage greater than \$1,500,000 you must provide a “proof of good health” statement for and be approved for the additional coverage.

The total maximum amount of term life insurance coverage under the Plan (Basic plus Supplemental) is \$2,000,000.

Supplemental Term Life Insurance – Family Coverage: A voluntary, employee-paid benefit providing 100% of the Employees Supplemental Term Life Amount up to \$100,000 of term life coverage for an employee’s spouse/domestic partner and \$10,000 of term life coverage for each eligible child. To elect coverage greater than \$50,000 for your spouse/domestic partner, you must provide a “proof of good health” statement for your spouse/domestic partner and be approved for the additional coverage.

Eligibility and Enrollment

Coverage under the Plan is available on the first day of employment for U.S. benefits-eligible employees (see the “Who Is Eligible for These Benefits” section). Coverage for hourly employees whose status changes to U.S. benefits-eligible is available on the date their status change takes effect.

Each April 1, Insurance Earnings are recalculated and employees whose Insurance Earnings increase to \$200,000 or more will automatically be transferred to Group Variable Universal Life, provided they satisfy all of the GVUL eligibility provisions. (See the “Group Variable Universal Life” section for details).

Enrollment in Basic Term Life and Accidental Death and Dismemberment is automatic.

Eligible employees who want Supplemental Term Life coverage must enroll **within 31 days of their date of hire**. Hourly employees whose status changes to U.S. benefits-eligible must enroll **within 31 days of their status change**.

Late Enrollment and Changes to Group Term Life Insurance Coverage

Employees who do not enroll for Supplemental Term Life Insurance within 31 days of becoming eligible (or who wish to increase coverage at a later date) will be required to furnish proof of good health before being permitted to enroll (or increase coverage) at a later date.

There is no scheduled open enrollment for Supplemental Term Life Insurance, but you can provide evidence of good health to increase your coverage at any time.

Cancellation or Reduction in Coverage

You may cancel or reduce your Supplemental Term Life Insurance coverage at any time by e-mailing or faxing a memo to the HR Service Center, Hrservices@lehman.com; Fax Number: 646-758-5200. Include your name and Social Security number in the memo.

Changes Without Proof of Good Health

Within 31 days of a change in your marital status (including legal separation) or the birth or adoption of a child you do not need proof of good health to change your coverage level, subject to the following restrictions:

- If you have previously enrolled in the Supplemental Term Life Program, you are allowed to increase your coverage by 1 times your Insurance Earnings, up to the plan maximum of 9x Insurance Earnings or \$1.9 million. Increase requests for more than 1 times Insurance Earnings require a proof of good health statement for the additional increase.
- If you are not currently enrolled in the Supplemental Term Life Program, you can enroll in the plan for up to 3 times your Insurance Earnings, up to a maximum of \$1.5 million. Enrollments in excess of these limits require a proof of good health statement for the additional increase.

To request a change, please send an e-mail to the HR Service Center and HRServices@lehman.com or a fax to 646-758-5200. The e-mail or fax should contain your social security number, the date if the event and the type of change you wish to make. An event will be opened and you will be able to make the necessary changes online through e-Benefits.

Use of Insurance Earnings for Life Insurance

Coverage amounts for Basic Term Life and Accidental Death and Dismemberment are based on your Insurance Earnings, rounded to the next higher \$1,000, and they change automatically with the annual recalculation of Insurance Earnings on April 1.

Coverage amounts for Supplemental Term Life Insurance are also based on your Insurance Earnings, rounded up to the next \$1,000. You may elect coverage from one- to nine-times Insurance Earnings. Your Supplemental Term Life Insurance coverage will change automatically each April 1 with the annual recalculation of Insurance Earnings.

If your Supplemental Term Life Insurance coverage amount increases because your Insurance Earnings have increased, you will not be required to submit proof of good health to the insurance company. Your increased coverage will be automatically adjusted after the April recalculation.

Reduction at Age 65 and Over

While you are an active employee, on the April 1 following your 65th birthday, your Basic Term Life and Accidental Death and Dismemberment coverages will be reduced by 35%. On the April 1 following your 70th birthday, your Basic Term Life and Accidental Death and Dismemberment coverages will be reduced by 60%. On the April 1 following your 75th birthday, your Basic Term Life and Accidental Death and Dismemberment coverages will be reduced by 75%. On the April 1 following your 80th birthday, your Basic Term Life and Accidental Death and Dismemberment coverages will be reduced by 80%. The reductions are made each year based on your re-calculated Insurance Earnings. You may convert the reduced portion of your insurance amount to an individual policy by contacting the HR Service Center within 31 days of the reduction. See the “Converting to an Individual Policy” section for details.

Cost of Coverage

Basic Life and Accidental Death and Dismemberment coverage are provided at no cost to the employee. However, if your Insurance Earnings are in excess of \$50,000, you may be taxed on the value of that excess. See the “Imputed Income” section below for details.

Premiums for Supplemental Term Life Insurance are calculated based on your age. Your premiums are recalculated each year, when Insurance Earnings are recalculated. The table below illustrates the age-based premiums in effect for 2008. These premiums have been set by MetLife and are not subsidized by the Firm.

Monthly Supplemental Premium Rates (Per \$1,000 of Coverage)

Employee Coverage		Family Coverage	
Your Age on April 1	Monthly Rate	Your Age on April 1	Monthly Rate
Under 30	\$.043	Under 30	\$.065
30-34	.060	30-34	.087
35-39	.069	35-39	.098
40-44	.086	40-44	.120
45-49	.120	45-49	.164
50-54	.206	50-54	.274
55-59	.335	55-59	.439
60-64	.566	60-64	.736
65-69	.987	65-69	1.275
70 and Over	1.707	70 and Over	2.199

Employee contributions for Supplemental Life Insurance are made on an after-tax basis and appear on your pay stub under “After-Tax Deductions.”

Imputed Income

Federal tax law permits employers to provide you with up to \$50,000 of firm-paid group term life insurance without creating additional taxable income. If you have over \$50,000 in Basic Life Insurance, you will have additional taxable income recognized under federal tax laws. This income appears on your pay stub under "Taxable Benefits."

Naming a Beneficiary

All eligible employees should designate a primary and contingent beneficiary for the Group Life Insurance Plans. A beneficiary is the person designated by you to receive, in the event of your death, the proceeds or benefits from the life insurance plans in which you are participating at the time of your death. In the event that your primary beneficiary pre-deceases you, your contingent beneficiary will receive the proceeds from your life insurance plans. If you do not designate a beneficiary, or if your beneficiary(ies) pre-decease you, the proceeds would be paid in the following order:

1. Your spouse, if alive;
2. Your child(ren), if there is no surviving spouse;
3. Your parent(s), if there is no surviving child;
4. Your sibling(s), if there is no surviving parent; or
5. Your estate, if there is no surviving sibling.

For all or part of your life insurance for your dependents, the proceeds would be paid in the following order:

1. You, if alive;
2. Your spouse, if you are not alive;
3. Your child(ren), if there is no surviving spouse;
4. Your parent(s), if there is no surviving child;
5. Your sibling(s), if there is no surviving parent; or
6. Your estate, if there is no surviving sibling

Beneficiary changes to Basic Life, Supplemental Life, Basic Accidental Death & Dismemberment and Personal Accident Insurance can be made at any time through the e-Benefits site or through the HR Service Center.

You should routinely review your beneficiary designation to ensure it reflects your current wishes.

Plan Benefits

Death Benefits

In the event of the death of a covered employee, the Group Term Life Insurance Plan will pay the total amount of coverage under Basic Life and Supplemental Life to the beneficiary(ies) named by the employee in their most recent beneficiary designation.

In addition, if, as a result of a bodily injury suffered in an accident, a covered employee dies within one year of the accident, the Group Term Life Insurance Plan will pay the total amount of Accidental Death and Dismemberment coverage to the beneficiary(ies) named by the employee on the most recent Designation of Beneficiary record on file.

Accidental Injury Benefits

If a covered employee suffers a bodily injury in an accident and if, within one year of the accident, the employee suffers a Covered Loss, the Group Term Life Insurance Plan will pay a benefit to the employee.

The following Covered Losses will result in a benefit to the employee of 100% of the total Accidental Death and Dismemberment coverage:

- Loss of life; or
- Brain Damage (as defined in the certificate of insurance).

The following Covered Losses will result in a benefit to the employee of 75% of the total Accidental Death and Dismemberment coverage:

- Loss of an arm permanently severed at or above the elbow; or
- Loss of an leg permanently severed at or above the knee.

The following Covered Losses will result in a benefit to the employee of 50% of the total Accidental Death and Dismemberment coverage:

- Loss of a hand, at or above the wrist but below the elbow;
- Loss of a foot, at or above the ankle but below the knee;
- Loss of sight in one eye;
- Loss of speech;
- Loss of hearing;
- Paralysis of both legs; or
- Paralysis of the arm and leg on either side of the body.

The following Covered Losses will result in a benefit to the employee of 25% of the total Accidental Death and Dismemberment coverage:

- Loss of the thumb and index finger of the same hand; or
- Paralysis of one arm or leg.

The Plan will pay a Coma benefit of 1% of the total Accidental Death and Dismemberment coverage for each month, beginning after the 7th day of the coma, for the duration of the coma to a maximum of 60 months.

The Plan will pay the a benefit for each Covered Loss resulting from the same accident. However, no more than the full amount of Accidental Death and Dismemberment coverage is payable for all losses which result from one accident.

Limitations on Benefits

The life insurance coverage for a resident of the state of Texas may not exceed the greater of \$250,000 or 7 times the individual's compensation. The maximum is combined for all MetLife insured group coverage's.

Under Family Coverage, the term life coverage for a child is only available for dependent children who are at least 15 days old.

Accidental Death and Dismemberment benefits are paid for losses caused by accidents only. No Accidental Death and Dismemberment benefits are payable for a death or loss caused or contributed to by any of the following:

- Bodily or mental infirmity
- Disease, ptomaines or bacterial infections, unless the infection results directly from an accidental injury
- Medical or surgical treatment, unless the surgery is needed because of an accidental injury
- Suicide or attempted suicide
- Intentionally self-inflicted injury
- War or any act of war (declared or undeclared)
- Any incident related to:
 - travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger;
 - parachuting or other descent from an aircraft, except for self-preservation;
- Travel in an aircraft or device used:
 - for testing or experimental purposes;
 - by or for any military authority; or
 - for travel or designed for travel beyond the earth's atmosphere;
- Committing or attempting to commit a felony;
- The voluntary intake or use by any means of:
 - any drug, medication or sedative, unless it is:
 - taken or used as prescribed by a Physician, or
 - an "over the counter" drug, medication or sedative taken as directed;
 - alcohol in combination with any drug, medication, or sedative; or
 - poison, gas, or fumes;
- Intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the accident

How to File a Claim

To report the death or accidental injury of a covered employee, contact the HR Service Center at 5-2363 (212-526-2363). A Benefits Representative will contact the employee's beneficiary(ies) directly in writing, requesting a copy of the death certificate and required tax information. In the case of a death or injury resulting from an accident, the Benefits Representative will request copies of accident/police reports as well as copies of any newspaper articles reporting the accident.

Death benefit information is confidential. No coverage or beneficiary information can be released without the beneficiary's consent. In the case of multiple beneficiaries, the HR Service Center will contact each beneficiary separately.

Converting Life Insurance to an Individual Policy

If any of your Basic and/or Supplemental Term Life Insurance coverage ceases because:

- Your employment terminates;
- You are no longer a U.S. benefits-eligible employee; or
- Because of age (as explained in the "Reduction at Age 65 and Over" section);

the amount of insurance which ceases may be converted to a personal life insurance policy. A lesser amount may be converted if you wish. No evidence of good health will be required.

If you wish to convert all or part of your Basic and/or Supplemental Term Life Insurance coverages to an individual policy with MetLife, contact the HR Service Center at 5-2363 (212-526-2363) and request a conversion application. You may request the application prior to your termination date.

The HR Service Center will complete the employer portion of the application and forward it to your home. Premium information will be indicated on the application. The premiums for the personal policy will be at MetLife's usual rates for the same policy issued to any other person of the same class of risk and age when the personal policy is to become effective. These premiums are higher than premium payroll deductions for active employees. After you have completed the application, forward it with your premium payment to the nearest address listed on the back of the application. MetLife must receive your application and premium payment within 31 days of the date your coverage ceases, or they will not issue an individual policy.

The converted policy will be a personal policy that is customarily being issued by MetLife for the amount being converted and for your age (nearest birthday) on the date it will be issued. It will not have disability or other benefits. The converted policy will take effect at the end of the 31-day period during which conversion is possible.

Group Variable Universal Life

What is Group Variable Universal Life (GVUL)?

All newly hired employees are eligible for the Group Term Life Insurance program on their first day of hire (see the “Eligibility and Enrollment” section).

Each April 1 the Firm recalculates Insurance Earnings. If your new Insurance Earnings are \$200,000 or more, your Supplemental Term Life Insurance and \$50,000 of your Basic Term Life Insurance will automatically be transferred to Group Variable Universal Life (“GVUL”) insurance with Massachusetts Mutual (“MassMutual”), provided you satisfy the other GVUL eligibility requirements. Not included in the transfer is the first \$50,000 of Basic Life insurance, which remains insured through MetLife.

In addition to the minimum Insurance Earnings, eligibility in the GVUL program is subject to certain eligibility requirements as outlined in the individual GVUL policies. These eligibility requirements include:

- You must be actively at work from January 1 to April 1 in the year the insurances transfer to the GVUL program.
- If you are not based in the U.S., you may not be eligible for the GVUL program or your coverage may be limited.

If your Insurance Earnings are \$200,000 or more, but you do not satisfy the GVUL eligibility requirements, you will remain in the Group Term Life Insurance Plan. Your Basic and Supplemental Term Life Insurance will transfer to the GVUL program on the first April 1 that you satisfy all of the GVUL eligibility requirements.

Eligible employees may elect GVUL coverage of one (1) times to five (5) times Insurance Earnings to a maximum of \$2.9 million. If you enroll within 31 days of first being eligible, your coverage is not subject to medical underwriting. If you enroll at a later date you will be required to show proof of good health.

For Example: Your 2007 Insurance Earnings are \$150,000 and you have elected Supplemental Life Insurance of two times earnings. Your coverage from April 1, 2007 through March 31, 2008 is as follows:

	Basic Life	Supplemental Life
Coverage Amount & Insurance Carrier	\$100,000 MetLife	\$300,000 MetLife
Type of Coverage	Term Life	Term Life

If, on April 1, 2008, your Insurance Earnings are re-calculated to be \$200,000, your new coverage will be as follows:

	Basic Life	Supplemental Life
Coverage Amount & Insurance Carrier	\$50,000 MetLife \$50,000 MassMutual	\$400,000 MassMutual
Type of Coverage	\$50,000 Term Life \$50,000 GVUL	GVUL

At the time your insurance coverage is converted, you will receive a package of information including application forms or directions on how to apply online. Due to the fact that GVUL coverages are individually owned policies, applications must be completed and signed by you, even for the coverage that is being provided by the Firm at no cost to you. Failure to complete the application process will result in a loss of your total GVUL coverage, including the portion of the coverage that is 100% Firm paid.

Personal Accident Insurance

The Personal Accident Insurance Plan (“the Plan”) is a fully insured accidental death and dismemberment plan underwritten by the Life Insurance Company of North America. The Plan provides accident coverage for yourself in addition to the Accidental Death and Dismemberment coverage provided by the Firm under the Group Term Life Insurance Plan. You may also elect family coverage under the Plan, as described below.

Eligibility and Enrollment

Coverage under the Plan is available on the first day of employment for U.S. benefits-eligible employees (see the “Who Is Eligible for These Benefits” section). Coverage for hourly employees whose status changes to U.S. benefits-eligible is available on the date your status changes.

You may enroll in the Plan or make changes to your enrollment at any time.

Coverage

You may elect coverage for yourself in multiples of \$10,000 up to a maximum of \$1,000,000. The amount of coverage you elect is known as the “principal sum” under the Plan. The principal sum is payable if you die as a result of an accidental injury that occurred while covered under this Plan. Partial payment may be made for accidental dismemberment.

Family Coverage

If you elect family coverage, you are covered for the amount you select: the “principal sum” described above. In addition, your spouse or domestic partner and/or dependent children are also covered. The amount of insurance applicable to members of your family is based on the composition of the family at the time of loss, and is expressed as a percentage of your principal sum. The following table shows the different coverage levels (all percentages are based off of the principal sum):

<u>Family Composition</u>	<u>Coverage Level</u>		
	<u>Employee</u>	<u>Spouse/Domestic Partner</u>	<u>Child*</u>
Employee with a spouse/domestic partner and dependent children	100%	50%	15%
Employee with a spouse/domestic partner but no dependent children	100%	60%	N/A
Employee with dependent children but no spouse/domestic partner	100%	N/A	20%

Coverage level for a child is subject to a \$100,000 maximum.

Examples of Family Coverage Benefit Calculations

1. An employee who had a spouse and dependent children loses their spouse in a covered accident. At the time of loss the employee's elected principal sum was \$100,000.

Principal Sum	\$100,000
Spouse coverage level	50%
Benefit Payable	\$50,000

2. An employee who had a domestic partner but no dependent children passes away in a covered accident. At the time of loss the employee's elected principal sum was \$250,000.

Principal Sum	\$250,000
Employee coverage level	100%
Benefit Payable	\$250,000

3. An employee with a dependent child but no spouse or domestic partner loses their child in a covered accident. At the time of loss the employee's elected principal sum was \$500,000.

Principal Sum	\$500,000
Employee coverage level	20%
Benefit Payable	\$100,000

Under family coverage, dependents include your spouse or domestic partner, up to 70 years of age, and unmarried, dependent children up to 19 years of age, or up to age 25 if the child is a full-time student at an accredited institution of higher learning. Coverage will be extended beyond age 19 for an unmarried dependent child who:

- Is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation or physical handicap; and
- Became disabled before age 19 (age 25 if a full-time student); and
- Is chiefly dependent upon you for support and maintenance.

Proof of the dependent's incapacity must be submitted 31 days prior to attainment of the age at which the coverage would otherwise have ended.

Cost of Coverage

When you enroll in the Plan, you elect a coverage amount for yourself: the "principal sum" as described in the "Coverage" section. The monthly cost for employee-only coverage is \$0.10 per \$10,000 of principal sum. Family coverage costs \$0.18 per \$10,000 of your principal sum. Deductions appear on your pay stub under "After-Tax Deductions."

Examples of Monthly Premiums for Personal Accident Insurance

Principal Sum	Employee Only	Family Plan
\$ 10,000	\$ 0.10	\$ 0.18
50,000	0.50	0.90
100,000	1.00	1.80
250,000	2.50	4.50
500,000	5.00	9.00
1,000,000	10.00	18.00

Plan Benefits

Employee Coverage

In the event of the death of a covered employee due to accidental bodily injury, the Plan will pay to the beneficiary the full amount of coverage (the principal sum). In order to be covered, the death must occur within one (1) year of the accident.

In the event a covered employee suffers a loss (other than death) as a result of accidental bodily injury, the Plan will pay to the employee the principal sum, or a portion of the principal sum. The loss must occur within one (1) year of the accident, and only the larger of the applicable sums will be paid if more than one loss results from the accident. The table below lists examples of accidental injuries covered under the Plan. A complete schedule of covered losses can be found in the underlying insurance contract. For a copy of the insurance contract, please contact the HR Service Center at 5-2363 (212-526-2363).

Examples of Accidental Injuries Covered Under the Plan:

Covered Loss	% of Principal Sum Payable to Employee
One hand or foot	50%
Thumb and index finger of same hand	25%
Total, permanent and irrecoverable loss of sight - both eyes	100%

Permanent Total Disability – Lump Sum Payment

Under the Plan, “permanent total disability” means that a covered employee is unable to engage in any occupation or employment for which he or she is suited by reason of education, training or experience for the remainder of his or her life.

The Plan will pay to a covered employee 1% of the Principal Sum (minus any sums paid for loss) for 100 months, after the covered employee has satisfied a 180 day elimination period, if the employee:

- Sustains permanent total disability because of a covered accidental bodily injury, within 180 days of the covered accident; and
- The permanent total disability continues for 180 days from the date of the accident.

Family Coverage

In the event of the death of a covered family member, the Plan will pay to the employee a portion of the principal sum as shown in the “Coverage” section. In the event a covered family member suffers a loss other than death, the Plan will pay to the employee a percentage of the family member portion of the principal sum as shown in the “Coverage” section.

Education Benefit

This benefit is payable to your qualified dependent child (or child’s legal guardian) if you elect family coverage under the Plan and you die or sustain a Permanent and Total Disability in a covered accident. In

addition to all other benefits, the insurance company will pay 5% of your coverage amount over a four-year (consecutive) period (to a maximum of \$7,500 per year) for each dependent child who:

On the date of the accident was enrolled as a full-time student in any institution of higher learning, or

Was in the 12th grade and within 365 days following the accident enrolls as a full-time student in an institution of higher learning. If no dependent child qualifies, \$1,000 is paid.

Spouse Retraining Benefit

If you elect family coverage and you die in a covered accident, your spouse or domestic partner may receive an additional employment retraining benefit of 5% of the principal sum, up to a maximum of \$7,500. Your spouse or domestic partner is eligible if, as a result of your death (within one year of the covered accident), he or she participates in a formal professional or trades training program for the purpose of obtaining an independent source of support and maintenance. The Plan will pay the actual cost of the retraining, up to 5% of the Principal Sum to a maximum of \$7,500, provided that the spouse or domestic partner enrolls in an accredited school within thirty (36) months from the date of your death.

Increased Accident Benefit for Your Dependent Children

Severe accidental injuries to a child can result in ongoing and significant medical expenses, rehabilitation programs and the need for a specialized education environment. To help parents cope with the financial consequences, if a covered dependent child sustains a covered loss (other than loss of life), the Plan will pay an amount equal to two (2) times the sum payable for that loss, to a maximum of \$100,000. However, this extra payment will only apply to the largest payment related to one accident. For example, a dependent child incurred 2 covered losses from one accident, one that would pay \$50,000 and one that would pay \$25,000 (based on the applicable principal sum and coverage levels). The plan would pay a benefit of \$125,000, \$75,000 for the total of the 2 covered losses and an additional \$50,000 under this provision.

Day Care Benefit

If you die from a covered injury within 365 days of the date of your accident, the Plan will pay an additional day care benefit for each eligible dependent child.

A dependent child is eligible if, at the time of your accident, he or she is attending a day care program or has been enrolled in a day care program and will be attending within 365 days of the date of your death. The child must be under age thirteen (13) at the time of your death.

This Plan will pay the actual day care cost up to a maximum benefit of \$3,000 annually over five (5) years, as long as the child is under age 13.

Additional Coverages

Accidental Death and Dismemberment benefits are provided under the following coverages. Any benefits payable under them are shown in the *Schedule of Covered Losses*, in the underlying Insurance Contract, and will not be paid in addition to any other Accidental Death and Dismemberment benefits payable.

Armed Forces Coverage

A benefit will be payable, subject to all applicable conditions and exclusions, if the Covered Person suffers a Covered Loss that results directly and independently of all other causes from a Covered Accident that occurs while he is on active duty in any Armed Forces.

National Guard and Armed Forces Reserve Coverage

A benefit will be payable, subject to all applicable conditions and exclusions, if the Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident that occurs while the Covered Person is a member of the U.S. Military Reserve or National Guard.

While the Covered Person is a member of the U.S. Military Reserve or National Guard, coverage under this Policy will remain in force beyond the 31-day active duty training period and continue:

- during the Covered Person's initial training period;
- if the Covered Person is called to active duty for a domestic emergency.

Owned Aircraft Coverage

A benefit will be payable, subject to all applicable conditions and exclusions, if the Covered Person suffers a Covered Loss that results directly and independently of all other causes from a Covered Accident that occurs during travel or flight in, including getting in or out of, any Aircraft that is owned, leased, operated or controlled by the Firm or any of its subsidiaries or affiliates. A record of eligible Aircraft will be maintained by the Firm and available for review by the insurer at any time upon their request. An Aircraft substituted for an eligible Aircraft will also be eligible if it has no greater seating capacity and the original Aircraft is withdrawn from normal use due to breakdown, repair, servicing, loss or destruction.

Pilot Coverage

A benefit will be payable, subject to all applicable conditions and exclusions, if the Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident that occurs while the Covered Person is flying as a licensed pilot or member of the crew of an Aircraft that meets all of the following requirements:

1. has submitted a completed Pilot Data History form and has been accepted for Pilot coverage by the Life Insurance Company of North America;
2. maintains the same level of qualification stated on the Pilot Data History form submitted to and approved by the Life Insurance Company of North America;
3. completes and maintains a combined minimum of 200 hours of military, private or professional logged flight hours
4. is flying as a pilot or member of the crew of an Aircraft for which he is qualified and on a list of eligible Aircraft maintained by the Firm, including a substitute Aircraft with no greater seating capacity while a listed Aircraft is withdrawn from normal use due to breakdown, repair, servicing, loss or destruction; and
5. is not giving or receiving flight instruction.

War Risk Coverage

A benefit will be payable, subject to all applicable conditions and exclusions, if the Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident

that occurs during war or acts of war that occur worldwide except for Afghanistan, Algeria, Chechnya, Iran, Iraq, Israel (including West Bank), Kuwait, Libya, Pakistan, Qatar, Saudi Arabia, Somalia, Turkey, and United Arab Emirates.

This benefit does not provide coverage when a Covered Loss occurs:

- in the United States and its territories and possessions; or
- in any nation of which the Covered Person is a citizen.

Benefit Reductions and Additional Benefits

Reduction at Age 70 and Over

While you are an active employee, upon attainment of certain ages, your coverage level will be reduced to a percentage of the Principal Sum. Please note that your premiums will still be based upon the Principal Sum, even though your coverage will be for a lower amount. Upon attainment of age 70, your coverage level will be reduced to 65% of your Principal Sum. Upon attainment of age 75, your coverage level will be reduced to 45% of your Principal Sum. Upon attainment of age 80, your coverage level will be reduced to 30% of your Principal Sum. Upon attainment of age 85, your coverage level will be reduced to 15% of your Principal Sum.

Exposure and Disappearance Benefit

If a Covered Person disappears and is not found within one year from the date of the wrecking, sinking or disappearance of the conveyance in which the Covered Person was riding in the course of a trip which would otherwise be covered under this Policy, it will be presumed that the Covered Person's death resulted directly and independently of all other causes from a Covered Accident and an additional benefit of 10% of the principal sum, up to a maximum of \$25,000, will be payable.

A Covered Loss resulting directly and independently of all other causes from unavoidable exposure to the elements following a Covered Accident will be covered under the Plan and a benefit will be paid out for a Covered Loss according to Schedule of Benefits for Covered Losses.

Seatbelt and Airbag Benefit

If a Covered Person dies directly and independently of all other causes from a Covered Accident while wearing a seatbelt and operating or riding as a passenger in an Automobile, a seatbelt benefit of 10% of the Principal Sum, up to a maximum of \$25,000, may be payable. An additional benefit of 5% of the Principal Sum, up to a maximum of \$5,000, is provided if the Covered Person was also positioned in a seat protected by a properly-functioning and properly deployed Supplemental Restraint System (Airbag).

If it is unclear whether the Covered Person was wearing a seatbelt or positioned in a seat protected by a properly functioning and properly deployed Supplemental Restraint System, a default benefit of \$1,000 may be paid to the Covered Person's beneficiary.

In the case of a child, seatbelt means a child restraint, as required by state law and approved by the National Highway Traffic Safety Administration, properly secured and being used as recommended by its manufacturer for children of like Age and weight at the time of the Covered Accident.

Home Alteration and Vehicle Modification Benefit

A Home Alteration and Vehicle Modification Benefit of 10% of the Principal Sum, up to a maximum of \$25,000, may be payable, subject to the following conditions and exclusions, when a Covered Person suffers a Covered Loss, other than a Loss of Life, resulting directly and independently of all other causes from a Covered Accident.

This benefit will be payable if all of the following conditions are met:

1. Prior to the date of the Covered Accident causing such Covered Loss, the Covered Person did not require the use of any adaptive devices or adaptation of residence and/or vehicle;
2. As a direct result of such Covered Loss, a Physician certifies that the Covered Person now requires such adaptive devices or adaptation of residence and/or vehicle to maintain an independent lifestyle;
3. The home alteration or vehicle modification is made:
 - a. by a person qualified to make such alteration or modification; and
 - b. in compliance with any applicable laws and regulations; and
 - c. expenses for home alterations or vehicle modifications do not exceed those for similar alterations or modifications in the locality where they were made; and
 - d. the Covered Person requires home alteration or vehicle modification within one year of the date of the Covered Accident.

Exclusions

In addition to any benefit-specific exclusions, benefits will not be paid for any Covered Injury or Covered Loss which, directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the *Description of Benefits* Section of the underlying insurance contract:

- intentionally self-inflicted Injury, suicide or any attempt thereat;
- commission or attempt to commit a felony;
- commission of or active participation in a riot or insurrection;
- bungee jumping; parachuting; skydiving; parasailing; hang-gliding;
- declared or undeclared war or act of war;
- flight in, boarding or alighting from an aircraft or any craft designed to fly above the earth's surface, except as:
 - a fare-paying passenger on a regularly scheduled commercial or charter airline;
 - a passenger in a non-scheduled, private aircraft used for pleasure purposes with no commercial intent during the flight; or
 - a passenger in a military aircraft flown by the air mobility command or its foreign equivalent;
- sickness, disease bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
- travel in any aircraft owned, leased or controlled by the Firm, or any of its subsidiaries or affiliates. An aircraft will be deemed to be controlled by the Firm if the aircraft may be used as the Firm wishes for more than 10 straight days, or more than 15 days in any year;
- a Covered Accident that occurs while engaged in the activities of active duty service in the military, navy or air force of any country or international organization. Covered Accidents that occur while

engaged in Reserve or National Guard training are not excluded until training extends beyond 31 days.

Benefits will not be paid for services or treatment rendered by a Physician, Nurse or any other person who is retained or employed by the Policyholder or is a parent, sibling, spouse or child of the Covered Person.

How to File a Claim

To report the accidental death or injury of a covered employee or family member, contact the HR Service Center at 5-2363 (212-526-2363). A Benefits Representative will contact the employee or the employee's beneficiary(ies), as applicable, directly in writing, requesting a copy of the death certificate, required tax information and copies of any and all accident/police reports as well as copies of any newspaper articles reporting the accident.

Any payment made under family coverage due to the death or injury of a covered dependent will be paid to the employee.

Death benefit information is confidential. No coverage or beneficiary information can be released without the beneficiary's consent. In the case of multiple beneficiaries, the HR Service Center will contact each beneficiary separately.

Converting to an Individual Policy

If you wish to convert all or a portion of your Personal Accident Insurance coverage to an individual policy with the Life Insurance Company of North America, contact the HR Service Center at 5-2363 (212-526-2363) and request a conversion application. You may request the application prior to your termination date.

Conversion coverage may not in any event exceed \$250,000.

The HR Service Center will complete the employer portion of the application and forward it to your home. Premium information will be indicated on the application. These premiums are significantly higher than premium payroll deductions for active employees. After you have completed the application, forward it with your premium payment to the address listed on the back of the application.

The Life Insurance Company of North America must receive your application and premium payment within 31 days of your date of termination, or they will not issue an individual policy.

Business Travel Accident

The Business Travel Accident Plan (the “Plan”) is underwritten by the Life Insurance Company of North America (Policy number ABL-980033). The Plan provides Firm-paid accidental death and dismemberment insurance for employees who are required to travel on behalf of the Firm. Business travel does not include your normal commute to and from your office.

Eligibility

All active regularly scheduled full-time employees of the Firm working 20 hours or more per week, regardless of home country location, and their guests are automatically covered under the Plan while traveling on behalf of the Firm. In addition, your spouse or domestic partner and dependent children (collectively “family members”) may also be covered.

Plan Benefits

The amount of coverage provided is based on the covered individual’s category, and the type of “loss” (including death) as described in the tables below.

Accidental Death Benefits

Employee Category	Death Benefits
All active full-time employees	5x Base pay, up to a maximum of \$500,000
All Guests (except family members and as listed below)	\$100,000

Accidental Injury Benefits

For accidental losses other than death, the Plan pays a percentage of the death benefit, if the loss occurs within 365 days of the covered accident. A complete schedule of covered losses can be found in the underlying insurance contract and is available upon request.

Covered Loss	% of Death Benefits Payable
Entire hand or foot	50%
Both hands or both feet	100%
Entire and irrecoverable loss of either speech or hearing	50%
Entire and irrecoverable loss of both speech and hearing	100%
Thumb and index finger of same hand	25%

Limitations

If a covered individual suffers more than one loss as a result of the same accident, the Plan will pay the greatest covered amount, but in no event more than the death benefit amount for that covered individual.

If one or more employees suffer a covered loss as a result of the same accident, the maximum the Plan will pay in the aggregate to all beneficiaries is \$30,000,000 on a prorated basis.

If one or more employees suffer a covered loss as a result of a single bomb scare, search or explosion that occurs on the Firm's premises, the maximum the Plan will pay in the aggregate to all beneficiaries is \$5,000,000 on a prorated basis.

Benefit Reductions and Additional Benefits

Reduction at Age 70 and Over

While you are an active employee, your coverage level will be reduced to a percentage of the Principal Sum. Upon attainment of age 70, your coverage level will be reduced to 65% of your Principal Sum. Upon attainment of age 75, your coverage level will be reduced to 45% of your Principal Sum. Upon attainment of age 80, your coverage level will be reduced to 30% of your Principal Sum. Upon attainment of age 85, your coverage level will be reduced to 15% of your Principal Sum.

Relocation Benefit

The spouse, domestic partner or dependent child of a covered employee may be covered by the Plan for any Covered Loss that occurs while relocating at the request of the Firm. Benefits payable for any loss or combination of losses are limited to 50% of the employee's principal sum, to a maximum of \$100,000 for a spouse or domestic partner and \$10,000 for a dependent child. To be eligible, a dependent child must be under age 19 and primarily dependent on the covered employee for support. Coverage may be extended to age 25 if the child is a full-time student attending an accredited college or university.

Common Carrier Coverage

A benefit will be payable, subject to all applicable conditions and exclusions, if the Covered Person suffers a Covered Loss that results, directly and independently of all other causes, from a Covered Accident that occurs while riding as a fare-paying passenger in, or being struck by, a Common Carrier. Riding includes getting into and out of the Common Carrier.

For purposes of this benefit, Common Carrier means:

- a public conveyance, including Aircraft, licensed for hire to carry fare-paying passengers; or
- a transport Aircraft operated by the Air Mobility Command of the United States of America or similar air transport service of another country.

Exposure and Disappearance Benefit

If a Covered Person disappears and is not found within one year from the date of the wrecking, sinking or disappearance of the conveyance in which the Covered Person was riding in the course of a trip which would otherwise be covered under this Policy, it will be presumed that the Covered Person's death resulted directly and independently of all other causes from a Covered Accident and a benefit of 10% of the principal sum, up to a maximum of \$25,000, will be payable.

A Covered Loss resulting directly and independently of all other causes from unavoidable exposure to the elements following a Covered Accident will be covered under the Plan and a benefit will be paid out for a Covered Loss according to Schedule of Benefits for Covered Losses.

Hijacking and Air Piracy Coverage

A benefit will be payable, subject to all applicable conditions and exclusions, if the Covered Person suffers a Covered Loss resulting, directly and independently of all other causes, from a Covered Accident that occurs during the hijacking, air piracy, or unlawful seizure or attempted seizure of an Aircraft.

Owned Aircraft Coverage

A benefit will be payable, subject to all applicable conditions and exclusions, if the Covered Person suffers a Covered Loss that results, directly and independently of all other causes, from a Covered Accident that occurs during travel or flight in, including getting in or out of, any Aircraft that is owned, leased, operated or controlled by the Firm or any of its subsidiaries or affiliates.

A record of eligible Aircraft must be maintained by the Firm and provided to the insurer upon request.

An Aircraft substituted for an eligible Aircraft will also be eligible if it is as similar to the original Aircraft in design and seating capacity as is available, and the original Aircraft is withdrawn from normal use due to breakdown, repair, servicing, loss or destruction.

An Aircraft controlled by the Firm is one available for its use for 10 or more consecutive days or for 15 days during any calendar year.

Felonious Assault and Violent Crime Benefit

An additional benefit of up to 25% of the Principal Sum, up to a maximum of \$100,000, will be payable, subject to all applicable conditions and exclusions, when a Covered Person suffers a Covered Loss resulting, directly and independently of all other causes, from a Covered Accident that occurs during a violent crime or felonious assault as described below. A police report detailing the felonious assault or violent crime must be provided before any benefits will be paid. The Covered Accident must occur while the Covered Person is on the business or premises of the Policyholder.

To qualify for benefit payment, the Covered Accident must occur during any of the following:

- actual or attempted robbery or holdup;
- actual or attempted kidnapping; or
- any other type of intentional assault that is a crime classified as a felony by the governing statute or common law in the state where the felony occurred.

In addition, a Hospital Stay Benefit of \$100 per day may be payable, subject to the following conditions and exclusions, when the Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident that occurs during a violent crime or felonious assault if all of the following conditions are met:

- the Covered Person is covered for Hospital Stay benefits under this Policy;
- the Hospital Stay begins within 30 days of the felonious assault/violent crime;
- the Hospital Stay is at the direction and under the care of a Physician;
- the Covered Person provides proof satisfactory to the insurer that the Hospital Stay was necessitated to treat Covered Injuries sustained in a Covered Accident caused solely by a violent crime or felonious assault;

- the Hospital Stay begins while the Covered Person's insurance is in effect.

The benefit will be paid for each day of a continuous Hospital Stay, but the Maximum Benefit Period is 365 days per hospital stay per covered accident.

Seatbelt and Airbag Benefit

If a Covered Person dies directly and independently of all other causes from a Covered Accident while wearing a seatbelt and operating or riding as a passenger in an Automobile, a seatbelt benefit of 10% of the Principal Sum, up to a maximum of \$50,000, may be payable. An additional benefit of 5% of the Principal Sum, up to a maximum of \$5,000, is provided if the Covered Person was also positioned in a seat protected by a properly-functioning and properly deployed Supplemental Restraint System (Airbag).

If it is unclear whether the Covered Person was wearing a seatbelt or positioned in a seat protected by a properly functioning and properly deployed Supplemental Restraint System, a default benefit may be paid to the Covered Person's beneficiary.

In the case of a child, seatbelt means a child restraint, as required by state law and approved by the National Highway Traffic Safety Administration, properly secured and being used as recommended by its manufacturer for children of like Age and weight at the time of the Covered Accident.

Covered Events

The Plan covers losses incurred while on assignment by or at the direction of the Firm for furthering the business interests of the Firm. Side trips of a personal nature are covered provided that the side trip is incidental to the business trip, would not have occurred if not for the business trip, and does not last longer than 72 hours.

In addition, the Plan covers losses sustained as the result of a bomb scare, bomb search or bomb explosion on the Firm's premises.

Travel required during a covered employee's relocation is considered business travel. Regular commutation travel from a covered employee's home is not considered business travel.

Losses Not Covered

In addition to any benefit-specific exclusion, benefits will not be paid for any Covered Injury or Covered Loss which directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the Conditions of Coverages and Description of Indemnity Benefits sections of the underlying insurance contract.

- Intentionally self-inflicted Injury, suicide or any attempt thereat while sane or insane;
- Commission or attempt to commit a felony or an assault;
- Commission of or active participation in a riot or insurrection;
- Declared or undeclared war or act of war;
- Flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface:
 - except as a fare-paying passenger on a regularly scheduled commercial or charter airline;
 - being flown by the Covered Person or in which the Covered Person is a member of the crew;
 - being used for:

- crop dusting, spraying or seeding, giving and receiving flying instruction, fire fighting, sky writing, sky diving or hang-gliding, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt or acrobatic flying; and
 - any operation that requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on);
- designed for flight above or beyond the earth's atmosphere;
- an ultra-light or glider;
- being used by any military authority, except an Aircraft used by the Air Mobility Command or its foreign equivalent;
- being used for the purpose of parachuting or skydiving;
- Travel in or on any on-road and off-road motorized vehicle except a golf cart, that does not require licensing as a motor vehicle;
- Participation in any motorized race or contest of speed;
- Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, including exposure, whether or not accidental, to viral, bacterial or chemical agents except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
- Travel in any Aircraft owned, leased or controlled by the Subscriber, or any of its subsidiaries or affiliates. An Aircraft will be deemed to be "controlled" by the Subscriber if the Aircraft may be used as the Subscriber wishes for more than 10 straight days, or more than 15 days in any year;
- Voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
- A Covered Accident that occurs while engaged in the activities of active duty service in the military, navy or air force of any country or international organization. Covered Accidents that occur while engaged in Reserve or National Guard training are not excluded until training extends beyond 31 days;
- Operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Covered Person has been provided a written warning against operating a vehicle while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Accident occurred;
- An Accident if the Covered Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license, unless: (a) the Covered Person holds a valid learners permit and (b) the Covered Person is receiving instruction from a Driver's Education Instructor.

In addition, benefits will not be paid for services or treatment rendered by any person who is:

1. employed or retained by the Subscriber;
2. living in the Covered Person's household;
3. a parent, sibling, spouse or child of either the Covered Person or the Covered Person's spouse;
4. the Covered Person.

Benefits will not be paid for the Covered Person's Covered Loss if:

1. he was driving a Private Passenger Automobile at the time of the Covered Accident that resulted in the Covered Loss; and

2. he was intoxicated, as that term is defined by the laws of the state in which the Covered Accident occurred.

Beneficiary

In the case of the accidental death of a covered employee, the beneficiary is the beneficiary designated by that employee for Group Life Insurance coverage (see the “Naming a Beneficiary” section). You may designate a different beneficiary through the e-Benefits Web page within the Benefits section of LehmanLive (keyword: eBenefits). In the case of the accidental death of a covered dependent, the beneficiary is the employee.

How to File a Claim

To report the death or accidental injury of a covered employee, contact the HR Service Center at 5-2363 (212-526-2363). In the event of the death of a covered employee, the Benefits Representative will contact the beneficiary(ies) directly in writing, requesting a copy of the death certificate, required tax information and copies of any and all accident/police reports as well as copies of any newspaper articles reporting the accident.

Death benefit information is confidential. No coverage or beneficiary information can be released without the beneficiary’s consent. In the case of multiple beneficiaries, the HR Service Center will contact each beneficiary separately.

Short Term Disability

The Short Term Disability (STD) Insurance Plan (the “STD Plan”), which is a fully insured plan, is a combination of state statutory programs and an insured program through MetLife. The Plan is designed to replace a portion of your income if you become totally disabled and cannot work. The “Definition of Totally Disabled” section under “Plan Benefits”.

Eligibility and Enrollment

STD coverage is available on the first day of employment for all U.S. benefits-eligible employees (see the “Who Is Eligible for These Benefits” section). Hourly employees whose status changes to U.S. benefits-eligible are eligible for STD coverage on the day their status change takes effect.

Plan Benefits

STD Benefits

The STD plan provides a benefit of up to \$500 a week or the state mandated maximum benefit as defined in the Benefit Programs section below. The benefits for employees working in California, Rhode Island, and Puerto Rico are paid directly by those states. The benefits for all other employees are paid by MetLife. All benefits under the STD plan must be coordinated with any benefit you may receive under the Firm’s salary continuation program.

STD benefit payments begin after you have been totally disabled and unable to work for more than 7 consecutive days. Benefits are payable through your 26th week of disability, at which time you would become eligible for Long Term Disability (“LTD”) benefits. Please see the LTD section of this document for a detailed description of the LTD program.

This benefit is provided by the Firm at no cost to you (except for certain required employee contributions in the statutory states). Enrollment in the STD Plan is automatic. STD benefits represent taxable income to you when paid.

Benefit Programs

Benefits paid directly by the individual states/territory

California – information on the California State Disability Insurance (SDI) program can be found at <http://www.edd.ca.gov/direp/diind.htm>

Puerto Rico - information on the Puerto Rico Temporary Disability Insurance (TDI) program can be found at <http://www.gobierno.pr/gprportal/inicio>

Rhode Island - information on the Rhode Island Temporary Disability Insurance (TDI) program can be found at <http://www.dlt.state.ri.us/tdi/>

Benefits paid through MetLife

The following lists the benefits available under the various STD programs that are paid through MetLife. Please contact the HR Service Center at HRServices@lehman.com or 212-526-2363 for more information regarding these STD programs.

- Hawaii - 58% of Insurance Earnings, maximum benefit is set by the state (2008 amount will be announced in December 2007)
- New Jersey – 66.67% of Insurance Earnings, maximum benefit is set by the state (\$524 for 2008)
- New York – 60% of Insurance Earnings, maximum benefit of \$500/week
- All other locations - 60% of Insurance Earnings, maximum benefit of \$500/week

Definition of “Totally Disabled”

Under the STD Plan, “Totally Disabled” is defined as the inability to perform all the essential duties of your occupation. The MetLife, or the administrator of the statutory program for employees located in California, Puerto Rico or Rhode Island, makes all determinations regarding whether you qualify for full or partial disability benefits under the STD Plan.

MetLife will not make a determination regarding your disability without your signed medical disclosure authorization form and necessary documentation from your physician. You must contact MetLife as soon as possible to ensure there are no delays in obtaining any authorized benefits.

Long Term Disability

The Long Term Disability (LTD) Insurance Plan (the “LTD Plan”), which is a fully insured plan, is insured by MetLife. The Plan is designed to replace a portion of your income if you become totally disabled and cannot work. The “Definition of Totally Disabled” section under “Plan Benefits”. LTD benefit payments begin after you have been totally disabled and unable to work for more than 180 consecutive days.

Eligibility and Enrollment

Both Basic LTD and Supplemental LTD coverages are available on the first day of employment for all U.S. benefits-eligible employees (see the “Who Is Eligible for These Benefits” section). Hourly employees whose status changes to U.S. benefits-eligible are eligible for LTD coverage on the day their status change takes effect.

Basic LTD

The Basic LTD plan provides coverage of 60% of your Insurance Earnings, up to a maximum of \$50,000 of Insurance Earnings. This benefit is provided by the Firm at no cost to you. Enrollment in the Basic LTD plan is automatic. Basic LTD benefits represent taxable income to you when paid.

Supplemental LTD

The Supplemental LTD plan provides coverage of 60% of your Insurance Earnings over \$50,000, up to a maximum of \$300,000 of Insurance Earnings.

Supplemental LTD coverage is not automatic. Eligible employees must enroll within 31 days of their date of hire, or within 31 days of becoming an eligible employee due to a change in status. If your Insurance Earnings on your date of hire (or status change) are \$50,000 or less, you will not pay a premium for Supplemental LTD coverage until your Insurance Earnings exceed \$50,000. Supplemental LTD benefits are not taxable to you when paid.

Late Enrollment/Changing Your Enrollment

Employees who do not enroll in Supplemental LTD coverage within 31 days of hire (or change in employment status) will be required to furnish proof of good health before being accepted for coverage at a later date.

You may be eligible to enroll in Supplemental LTD without providing proof of good health if you undergo one of the family status changes listed below. If you have a family status change, you have 31 days from the qualifying event to enroll in Supplemental LTD. Send an email to the HR Service Center at hrservices@lehman.com with your name, social security number, event type and date of the event. An event will be created and you will need to go through the e-Benefits Web page within the Benefits section of LehmanLive (keyword: eBenefits) to make the changes.

The following constitute a Qualified Family Status Changes:

- Marriage or domestic partnership;
- Divorce, legal separation or termination of domestic partnership;

- Birth or adoption of a child; legal guardianship of a child;
- Spouse or domestic partner becomes unemployed, loses coverage or takes unpaid leave of absence;
- Employee takes an unpaid leave of absence;
- Dependent child returns to school full-time;
- Death of a dependent;
- Spouse or domestic partner becomes employed.

Use of Insurance Earnings to Determine LTD Benefits

Coverage amounts for Basic and Supplemental LTD are based on your Insurance Earnings, and change automatically with the annual recalculation of Insurance Earnings on April 1st. If your Insurance Earnings increase, your LTD coverage will also increase, unless you have reached the maximum (\$50,000 for Basic, \$300,000 for Supplemental). If your Insurance Earnings decrease, your LTD coverage will also decrease.

If your coverage amounts increase because your Insurance Earnings have increased, you will not be required to submit proof of good health to the insurance company. Your increased coverage will be adjusted automatically after the April 1st recalculation.

If you become disabled, your benefit amount is based on the Insurance Earnings in effect on the last day you worked. See the “Monthly Benefit Calculation” section in “Plan Benefits” for details.

Cost of Coverage

Your annual cost for Supplemental LTD coverage is \$0.33 per \$100 of Insurance Earnings in excess of \$50,000 to a maximum of \$300,000 of Insurance Earnings.

For example, if your Insurance Earnings are \$150,000, the first \$50,000 of your earnings is insured under the Basic LTD Plan at no cost to you. The additional \$100,000 of your earnings is insured under the Supplemental LTD Plan at a cost of \$330 per year (\$27.50 per month). Monthly premiums are calculated by dividing the annual cost by 12. Examples of monthly premiums can be found on the chart below.

Examples of LTD Premiums and Benefits

Insurance Earnings	Annual Disability Income	Monthly Disability Benefit	Monthly Premium
\$25,000	\$15,000	\$1,250	Firm-paid
\$50,000	\$30,000	\$2,500	Firm-paid
\$100,000	\$60,000	\$5,000	\$13.75
\$150,000	\$90,000	\$7,500	\$27.50
\$200,000	\$120,000	\$10,000	\$41.25
\$250,000	\$150,000	\$12,500	\$55.00
\$300,000	\$180,000	\$15,000	\$68.75
Over \$300,000	\$180,000	\$15,000	\$68.75

Employee contributions for Supplemental LTD coverage are made on an after-tax basis. Deductions for Supplemental LTD coverage will appear on your pay stub under “After-Tax Deductions.”

Plan Benefits

The LTD Plan insures a percentage of your Insurance Earnings. If you elect Supplemental LTD coverage and your Insurance Earnings are \$150,000, for example, your premiums and coverage are based on those earnings, not the maximum earnings of the Plan.

Definition of “Totally Disabled”

Under the LTD Plan, “Totally Disabled” is defined as the inability to perform all the essential duties of your occupation.

If you are enrolled in the Basic and Supplemental LTD plans, the definition of Totally Disabled listed above will be in effect until the later of age 65 or your Disability End Date.

If you are only enrolled in the Basic LTD plan, after monthly benefits have been payable for 24 months, “total disability” is defined as the inability to perform all the essential duties of any occupation for which you are or may reasonably become qualified based on your education, training or experience.

Determinations

The insurance company makes all determinations of whether you qualify for full or partial disability benefits under the LTD Plan.

Partial Disability

Partial disability means that, because of illness or injury, you are unable to perform all essential duties of your own occupation on a full-time basis, but:

You are able to perform at least **one** of the material duties of your own or another occupation on a part-time or full-time basis; and

You are now earning **at least 20%** less than your indexed prior earnings, due solely to that disability.

Your partial disability monthly benefit is calculated based on a percentage of earnings and of total disability benefits. **For example**, if your earnings while partially disabled equal 40% of your earnings before you were disabled, your partial disability monthly benefit would equal 60% of your total disability monthly benefit.

Partial disability must start within 31 days after the end of a period of total disability for which monthly benefits are payable and must result from the same injury or sickness that caused you to be totally disabled.

Successive Periods of Disability

Separate periods of total disability resulting from the same or related causes will be considered one period of total disability unless separated by your return to active service for at least six (6) consecutive months.

Separate periods of total disability resulting from unrelated causes will be considered one period of total disability unless separated by your return to active service for at least one (1) full day.

Monthly Benefit Calculation

The LTD Plan is designed to provide you with income while you are unable to work due to a covered disability. The term “monthly benefit” refers to the amount payable to you on a monthly basis under the terms of the LTD Plan. Your monthly benefit is determined based on your Insurance Earnings in effect your last day worked and is calculated by taking 60% of your Insurance Earnings (or the coverage maximum, whichever is less) and dividing it by 12.

For example, if you become disabled and your last day of work is November 11, 2007, you will become eligible for monthly benefits beginning May 9, 2007. However, your benefit amount is based on the Insurance Earnings in effect on the last day you worked. In this example, the Insurance Earnings in effect would be those calculated on April 1, 2007 or your date of hire, if later, but not those recalculated on April 1, 2008.

Length of Disability

When Monthly Benefits Begin

If you become totally disabled while covered under the LTD Plan, you will be eligible to receive monthly benefits beginning on the 181st day following your last day worked.

When Monthly Benefits End

Except for disabilities contributed to or caused by mental illness or substance abuse (see the “Mental Illness and/or Substance Abuse” section under “Limitations and Exclusions”), monthly benefits will end on the earlier of:

The date you are no longer disabled (as determined by the insurer), or

Whichever of the end dates on the table is applicable to you.

Disability End Dates

Age When Total Disability Begins	Date Monthly Benefits End
Age 62 or Under	Later of: (i) your 65th birthday; or (ii) date the 42nd monthly benefit is payable
Age 63	Date the 36th monthly benefit is payable
Age 64	Date the 30th monthly benefit is payable
Age 65	Date the 24th monthly benefit is payable
Age 66	Date the 21st monthly benefit is payable
Age 67	Date the 18th monthly benefit is payable
Age 68	Date the 15th monthly benefit is payable
Age 69 or Over	Date of the 12th monthly benefit is payable

Benefit Offset

The actual amount of your monthly LTD benefits will take into consideration other disability income you receive. The LTD benefit will be reduced by the following:

- Any amounts you or your dependents receive on account of your disability under:
 - The Firm's salary continuation policy;
 - Any state disability or retirement benefits which you receive, or are assumed to receive (see "Assumed Receipt of Benefits" below) on your own behalf;
 - Any group or franchise insurance or similar plan for persons in a group; the Canada and Quebec Pension Plans;
 - Any local, provincial or federal government disability or retirement plan or law;
 - The Jones Act, or any workers' compensation, occupational disease or similar law including all permanent as well as temporary disability benefits; and
 - Any work loss provision in the mandatory part of any "No-Fault" auto insurance policy;
 - Unemployment Insurance Law or Program;
 - Work Earnings and Rehabilitation Incentive.
- Any disability or old age benefits payable under the federal Social Security Act which you receive or are assumed to receive (see "Assumed Receipt of Benefits" below) on your own behalf, on behalf of your dependents, or which your dependents receive on account of your receipt or assumed receipt (see "Assumed Receipt of Benefits" below) of such benefits.
- Any retirement benefits which you receive under (a) the Lehman Brothers Holdings Inc. Retirement Plan; (b) the Railroad Retirement Act or the Railroad Unemployment Act, to the extent these benefits are funded by the Employer.

Payments under an individually owned disability policy do not reduce your benefit under the Firm-sponsored LTD Plan.

Assumed Receipt of Benefits

If you are covered under the U.S. Social Security Act for any disability or old age benefit, state disability (if applicable), workers' compensation or similar laws, you must file for these benefits and you will be assumed to be receiving such benefits for yourself (and for your dependents, if applicable). These "assumed benefits" will be the amount the insurance company estimates you (and your dependents, if applicable) are eligible to receive. This assumption will not be made if you give proof that:

1. You have applied for these benefits; and
2. Payments were denied.

However, if payments for disability are denied solely because your disability is not expected to last at least 12 consecutive months, you will be assumed to be receiving such benefits after your disability has continued for 12 consecutive months. This assumption will not be made if you give proof that:

1. You have re-applied for these benefits; and
2. Payments were again denied.

MetLife will not assume receipt of, nor reduce your monthly benefits by, any elective, actuarially reduced early retirement benefits under such laws unless and until you actually receive such benefits.

Maximum Monthly Benefits

The maximum monthly benefit is \$2,500 under the Basic LTD Plan and \$12,500 under the Supplemental LTD Plan, for a total (including family Social Security disability) of \$15,000. This benefit is reduced by any other disability or retirement or pension benefit. See the “Benefit Offset” section above.

Family Survivor Benefits

If you die while you are receiving a monthly LTD benefit and you had collected LTD monthly benefits for a least six (6) months at the time of your death, your eligible survivor may be eligible to receive a survivor benefit equal to three (3) times your monthly LTD benefit. Your eligible survivor is your lawful spouse; otherwise, your unmarried child(ren) under age 25 who are living with you at the time of your death, in equal shares. Family survivor benefits will not be paid if there is no lawful spouse or any unmarried child(ren).

Lehman Brothers Benefits

If you were enrolled in the Medical, Dental or Vision Plan while you were active, you are entitled to continue your coverage while you are on LTD. You will be required to pay the employee cost of the premiums (equal to the active employee premium) and the Firm will pay the employer cost. MetLife can deduct those payments automatically from your LTD disability benefit check. Your eligible dependents can remain enrolled as long as they meet the eligibility requirements. You cannot add additional dependents while you are on LTD.

Your Basic Group Term Life Insurance remains in effect. You may elect to continue your Supplemental Group Term Life insurance without continuing to pay premiums if you complete a waiver of premium form and submit to MetLife. MassMutual will contact you directly regarding premium payments to continue GVUL coverage.

You can continue to keep your Flexible Spending Account active for the remainder of the first calendar year in which you become disabled through COBRA. Contributions to your account will be made on an after-tax basis.

At such time that you are no longer disabled or eligible for LTD benefits (e.g. reach age 65), your Lehman Brothers benefits will cease effective immediately.

Limitations and Exclusions

Pre-existing Condition Exclusion

If you become disabled during your first 12 months of coverage under the LTD Plan, no benefits will be paid if your disability results directly or indirectly from a “pre-existing condition.”

A pre-existing condition is defined as an injury or sickness in which, during the three (3) months prior to becoming covered under the Plan, you:

- Incurred expenses;
- Received medical treatment;
- Took prescribed drugs or medicines; or
- Consulted a physician.

Mental Illness and/or Substance Abuse

The Plan will pay monthly benefits for no more than 24 months during your lifetime for any total disability or partial disability caused or contributed to by one or more of the following:

- Alcoholism
- Psychotic, depressive, anxiety or eating disorders
- Delusional (paranoid) disorders
- Drug addiction or abuse
- Somatoform disorders (psychosomatic illness)
- Mental illness

This limitation does not apply for any period of time during which an employee is confined for more than 14 consecutive days in a hospital licensed to provide care and treatment for the condition causing total disability.

You will be considered confined in a hospital only if you are confined continuously for at least 14 days in a hospital licensed to provide care and treatment for the condition causing the total disability.

Other Exclusions

The LTD Plan does not cover any disability caused by or resulting from the following:

- War, declared or undeclared, or any act of war;
- Intentionally self-inflicted injuries;
- Committing a felony; or
- Active participation in a riot.

No monthly benefit will be paid for any period of total disability when you are not under the care of a licensed physician.

No benefits will be paid for any period of partial disability during which your loss of earnings is not solely due to disability.

How to File a Claim

If you become unable to work due to illness or injury, contact the Lehman Brothers HR Service Center at 5-2363 (212-526-2363) to begin processing your claim for disability benefits. If your disability lasts longer than three (3) months, you will be contacted by both the HR Service Center and the MetLife Insurance Company, the LTD Plan's insurance company, to begin the LTD claims process.

Under this Plan, you are required to file for Social Security disability benefits. Also, if you are age 65 or older, you are required to begin collecting your Lehman Brothers Holdings Inc. Retirement Plan benefit. See the "Assumed Receipt of Benefits" section under "Plan Benefits."

You will not qualify for LTD monthly benefits until after the 180-day waiting period has been satisfied. However, you will be asked to supply certain information in advance of that date in order to ensure that your monthly benefits begin as soon as your claim has been approved.

MetLife will supply you with the necessary claim forms and will require proof of disability from your doctor. This proof must describe the occurrence, character and extent of your disability. In addition, the

insurance company has the right, at its expense, to examine you as often as they may reasonably require in order to ascertain the extent of your disability.

Converting Your LTD Coverage

You will be entitled to convert your LTD Plan coverage to a conversion policy if:

- Your coverage under the Plan ends due to resignation or involuntary termination of employment; and
- You have been insured under the LTD Plan for at least 12 consecutive months.

You are not entitled to convert your coverage to an individual policy if:

- Your employment status changes to hourly, seasonal or temporary; or
- You have attained age 70; or
- You are retired.

ERISA Rights and Other Important Information

Plan Administration

There may be times when you need special information about the Lehman Brothers Holdings Inc. Group Benefits Plan (the “Plan”). This section provides technical information about the Plan. It is also designed to make information on the Plan easier to find.

Sponsoring Employer and Funding

The Plan is sponsored by:	The Sponsor’s Employer Identification Number is:
Lehman Brothers Holdings Inc. 745 7th Avenue New York, NY 10019	13-3216325

The self-funded benefits under the Plan (the Medical Plan, Dental Plan and the Flexible Spending Accounts) are funded by employee and Firm contributions. Benefits under these self-funded benefits are not guaranteed or insured. Firm contributions are made directly from general assets of the Firm.

The method for funding the insured benefits (the Vision Care, Group Term Life, Personal Accident Insurance, Business Travel Accident and Long Term Disability Plans) is for the Firm to pay premiums for the insurance benefits from its general assets, after any required contribution for insurance benefits are obtained from the employees by payroll deduction. To the extent that the premiums paid, other than premiums paid for coverage provided on a pooled basis, exceed the final premium costs for any policy year, the excess will be returned to and retained by the Firm and will not become an asset of the Plan. However, for the insured parts of the Plan which require employee contributions, to the extent such premium excess exceeds the Firm’s contributions for the insurance premiums, including the costs expended to administer the Plan, that amount will be applied by the Firm for the sole benefit of the employees participating in the Plan.

Plan Type and Plan Year

The Plan is a welfare benefit plan and a section 125 fringe benefit plan under the Internal Revenue Service guidelines for employer-sponsored benefit plans.

The Plan year is January 1 through December 31.

Agent for Legal Service

The agent for service of legal process for the Plan is:

Chairperson of the Employee Benefit Plans Committee
Lehman Brothers HR Service Center
1301 Avenue of the Americas, 6th Floor
New York, NY 10019

However, service of legal process may also be made on the Plan Administrator described in the “Plan Administrator” section below.

Plan Administrator

The Medical and Dental Plans and the Flexible Spending Accounts are administered by the Employee Benefit Plans Committee of Lehman Brothers Holdings Inc. (the "Committee"). The Committee can be reached at:

Employee Benefit Plans Committee
c/o HR Service Center
Lehman Brothers Inc.
1301 Avenue of the Americas, 6th Floor
New York, NY 10019
212-526-2363

The Plan Administrator is responsible for the operation and general administration of the Plan. The Committee has appointed a "Claims Administrator" for the Medical, Dental and Flexible Spending Account Plans to act on the Committee's behalf in administering and processing claims submitted under those plans. See the table below for the name and address of the Claims Administrators.

Claims Administrators

Benefit Plan	Claims Administrator
Aetna Choice POS II (Medical)	Aetna Life Insurance Company P.O. Box 981106 El Paso, TX 79998-1106
MetLife (Dental)	MetLife Dental P.O. Box 981282 El Paso, TX 79998-1282
Flexible Spending Account	WageWorks 4129 East Van Buren Suite 220A Phoenix, AZ 85008

The Vision Care, Group Term Life, Personal Accident Insurance, Business Travel Accident and Long Term Disability plans are each administered by the underwriting insurance company. See the table below for the names and addresses of the various plan administrators.

Benefit Plan	Plan Administrator
Vision Care	Davis Vision P.O. Box 2270 Schenectady, NY 12301
Group Term Life Insurance	MetLife P.O. Box 6115 Utica, NY 13504-6115
Personal Accident Insurance and Business Travel Accident	Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192-2235
Long Term Disability	Met Life P.O. Box 14590 Lexington, KY 40511-4590

Plan Administrators

The Plan Administrator has the discretionary authority to make all decisions in connection with the administration of the welfare benefit plans including, but not limited to, decisions concerning the eligibility of any person to participate in the welfare benefit plans and any benefits to which a participant or beneficiary is entitled. The Plan Administrator is the final authority concerning the welfare benefit plans. The Plan Administrator may adopt rules and regulations for administering the welfare benefit plans, including the limits on salary deductions. The Plan Administrator may prescribe forms for use by participants and their beneficiaries in communicating with the Plan Administrator. The Plan Administrator may establish periods during which communications or elections may be received. The Plan Administrator is not required to accept or give effect to any communications or elections which are not made on the forms provided or filed during the required periods.

Pursuant to procedures established by the Plan Administrator, any participant whose claim for benefits under a welfare benefit plan has been denied has the right to appeal such denial to the Plan Administrator for its review. Decisions and determinations of the Plan Administrator are final, conclusive and binding upon all parties, including the Firm, its employees, the participants and their beneficiary or beneficiaries.

Claiming Your Benefits

You may file claims for Plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative. If your claim is denied in whole or in part, you will receive a written notice of the denial. The notice will explain the reason for the denial and the review procedures.

An “authorized representative” means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf, except that in the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative.

Group Health Urgent Care Claims

If a group health plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if the Plan or your physician determines that it is an urgent care claim, you will be notified of the decision not later than 72 hours after the claim is received.

“Urgent Care” means services received for a sudden illness, injury or condition that is not an emergency condition but requires immediate outpatient medical care that cannot be postponed. An urgent situation is one that is severe enough to require prompt medical attention to avoid serious deterioration of a person’s health; this includes a condition that would subject a person to severe pain that could not be adequately managed without prompt treatment.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 24 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Group Health Pre-Service and Post-Service

If a group health Plan requires you to obtain advance approval of a service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For other group health claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim.

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside the Plan's control. In that case, you will be notified of the extension before the end of the initial 15 or 30 day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the Plan's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to a Plan representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

Ongoing Course of Treatment

If you are receiving an ongoing course of medical treatment, you will be notified in advance if the Plan intends to terminate or reduce benefits for the course of treatment so that you will have an opportunity to appeal the decision before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

Disability/Other Claims

For disability claims, you will be notified of the Claims Administrator's determination no later than 45 days after receipt of your claim. For all other claims you will be notified no later than 90 days after receipt of the claim.

Appealing Your Claim

It is possible for an error to occur in your records or in processing your claim. For this reason, there is an appeals procedure which is available to you if your claim is denied.

You will have two levels of appeal for both administrative and clinical appeals in accordance with the definitions below.

Administrative appeals are defined as appeals in response to denials based on contractual or benefit exclusion, limitation, or exhaustion not requiring clinical judgment. Administrative denials do not require a clinician to interpret the contractual limitation or apply clinical judgment to the limitation.

Clinical appeals are defined as appeals in response to denials based on clinical judgment for the determination and application the terms of the plan to the member's medical circumstances

You will have 180 days following receipt of an adverse benefit decision to appeal the decision to the Claims Administrator. For group health portions of the Plan, you will be notified of the decision not later than 15 days (for pre-service claims, or 30 days for post-service claims, after the appeal is received. For disability claims, you will be notified within 45 days after the appeal is received. For all other claims, you will be notified within 60 days after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

If your claim involves urgent care under the Medical Plan, an expedited appeal may be initiated by a telephone call to Member Services. Aetna's Member Services telephone number is on your Identification Card.

You or your authorized representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and the Plan by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with an appeal decision that involves urgent care, you may file a second level appeal to the Claims Administrator on an expedited basis. The second level appeal will be processed in the same manner as the first level appeal and you will be notified of the decision by the Claims Administrator no later than 36 hours after the appeal is received.

If you are dissatisfied with the appeal decision other than urgent care, you may file a second level appeal to the Company within 60 days of receipt of the level one appeal decision. Send your appeal request to the Claims Administrator and they will forward your appeal request and any additional information you have provided, along with the level one appeal file, to the Company. The Company will notify you of the decision no later than 15 days for pre-service claims 30 days for post-service claims, 45 days for disability claims, or 60 days for all other claims, after the appeal is received.

If your claim is denied in whole or in part, you will be notified in writing of:

1. The reason(s) for the denial, with reference to the specific Plan provisions on which the denial is based;
2. A description of any additional material needed to be filed with your claim, and an explanation as to why such information is needed; incomplete claims will be treated as part of the request for information and extension process and not as a denial unless you do not respond to the request for information within the required time period;
3. Instructions and deadlines for how to make an appeal, including a statement of your right to file a lawsuit under ERISA if your appeal is denied; and
4. In the case of a health care claim involving urgent care, a description of the expedited review process for these types of claims

Exhaustion of Process

You must exhaust the applicable Level one and Level two processes of the Appeal Procedure before you establish any:

- litigation;
- arbitration; or
- administrative proceeding:

- regarding an alleged breach of the policy terms by Aetna Life Insurance Company; or
- regarding any matter within the scope of the Appeals Procedure.

Health Claims – Voluntary Appeals

You may file a voluntary appeal for external review of any final standard appeal determination that qualifies.

You must complete all of the levels of standard appeal described above before you can appeal for external review. Subject to verification procedures that the Plan may establish, your authorized representative may act on your behalf in filing and pursuing this voluntary appeal. You must request this voluntary level of review within 60 days after you receive the final denial notice under the standard appeal processes.

If you file a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action.

If you choose not to file for voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

Health Claim Appeals for External Review

Aetna's external review process gives members the opportunity to have certain coverage denials reviewed by independent physician reviewers. An appeal will be eligible for external review if the following are satisfied:

1. the standard levels of appeal have been exhausted,
2. the appeal is made by the member or the member's authorized representative,
3. the coverage denial is based on Aetna's determination that the proposed or rendered service or supply is not medically necessary or is experimental or investigational, and
4. the cost of the service or supply at issue for which the member is financially responsible exceeds \$500.

If upon the final standard level of appeal the Company upholds the coverage denial and it is determined that the member is eligible for external review, the member will be informed in writing of the steps necessary to request an external review.

An independent review organization (IRO) refers the case for review by a neutral, independent physician with appropriate expertise in the area in question. Once all necessary information is submitted, the external review requests will generally be decided within 30 days of the request. Expedited reviews are available when a member's physician certifies that a delay in service would jeopardize the member's health. The decision of the independent external expert reviewer is binding on Aetna, the Company and the Health Plan. Members will not be charged a professional fee for the review.

Appeal to Plan Administrator

If a denial of benefits is upheld following the Level two process of the Appeal Procedure, you have the right to appeal to the Plan Administrator. With the exception of urgent care claims, you will have 180 days following receipt of an adverse benefit decision to appeal the decision. You must submit a complete, written application to the Plan Administrator requesting that your claim be reconsidered. You must state the reason(s) you think there is an error. Also, whenever possible, send copies of any documents or records that support your appeal. Whether or not you can provide such additional

information, your claim will be thoroughly reconsidered after your request is received. You are entitled to review all the Plan documents when you prepare your appeal and to have a qualified person represent you, at your own expense, during the appeals process.

You will be notified of the decision no later than 30 days (for pre-service claims) or 60 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

All decisions of the Plan Administrator are final, conclusive and binding. If, however, you believe that the Plan Administrator did not follow the terms of the Plan or has violated law, you may bring a legal action under ERISA. See the “ERISA Rights” section.

You may not bring a lawsuit to recover benefits under this Plan until you have exhausted the Plan’s mandatory levels of administrative process as described in this Summary Plan Description. If your appeal is denied you have the right to file a lawsuit under ERISA, provided you do so before the earliest of:

- Six months following the date your appeal has been denied
- Three years following the services related to the amount you are appealing were performed, or
- The end of the otherwise applicable statutory limitation period.

ERISA Rights

As a participant in the group benefit plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

Continue Group Health Plan Coverage

Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such

coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months after your enrollment date in your coverage under this Plan. Contact your Plan Administrator for assistance in obtaining a certificate of creditable coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the Plan’s money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact:

- The nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory; or
- The Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) directed the Department of Health and Human Services to issue regulations protecting the privacy and confidentiality of individual health information.

In connection with the HIPAA rules, the Plan has been amended to permit the Firm to receive certain participant health information. The Firm only will request this information if it needs it to help administer the Plan, such as to help resolve disputed claims. The Firm will protect the confidentiality of any health information that it does receive.

As part of the HIPAA rules, a health plan must notify its participants and beneficiaries about the policies and practices the plan adopted to protect the confidentiality of the participants’ health information. For this purpose, the Plan has prepared a Privacy Statement, which has been separately distributed to you and also is available on the Firm’s website.

The Plan’s Privacy Statement describes the Plan’s health information privacy policy regarding the Aetna Open Choice POS II and its related prescription drug benefits, the MetLife Dental Plan and the Health Care Flexible Spending Account (“FSA”). The Privacy Statement is intended to inform you of:

- your rights regarding your personal health information,
- the way the Plan may use and disclose health information about you, and
- the obligations the Plan has regarding the use and disclosure of your health information.

If you are enrolled in the International Medical Plan, International Dental Plan or if you are enrolled in the Davis Vision Care Plan, you should receive a separate privacy notice from your benefits provider that outlines the privacy policies and practices of your specific benefits option.

The Plan’s Privacy Statement also does not address the privacy policies or practices of your health care providers.

Other Important Information

Changing or Terminating the Plans

The Firm reserves the right to amend or terminate any or all of the Plans at any time without prior notice or consent. The Firm’s decision to amend or terminate a Plan may be due to changes in federal or state laws governing retirement benefits, the requirements of the Internal Revenue Code or the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), employee or Firm needs, or for any other reason. Plan participants will be given additional information in the event a Plan is amended or terminated.

Pension Benefit Guarantee Corporation

Benefits under the welfare benefit plans are not insured by the Pension Benefit Guaranty Corporation or any other governmental agency.

EXHIBIT E

**UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK**

In re	
LEHMAN BROTHERS INC.,	Case No. 08-01420 (SCC) SIPA
Debtor.	

**[PROPOSED] ORDER GRANTING THE TRUSTEE’S TWO HUNDRED FIFTY-SIXTH
OMNIBUS OBJECTION TO GENERAL CREDITOR CLAIMS
(EMPLOYEE CLAIMS)**

Upon the two hundred fifty-sixth omnibus objection to claims, dated August 1, 2014 (the “Two Hundred Fifty-Sixth Omnibus Objection to General Creditor Claims”),¹ of James W. Giddens (the “Trustee”), as trustee for the liquidation of Lehman Brothers Inc. (the “Debtor” or “LBI”) under the Securities Investor Protection Act of 1970, as amended, 15 U.S.C. §§ 78aaa *et seq.* (“SIPA”), seeking entry of an order, pursuant to section 502(b) of title 11 of the United States Code (the “Bankruptcy Code”), as made applicable to this proceeding pursuant to sections 78fff(b) and 78fff-1(a) of SIPA, and Rule 3007(d) of the Federal Rules of Bankruptcy Procedure (the “Bankruptcy Rules”), (i) disallowing and expunging in part certain proofs of claim (ii) subordinating and reclassifying as equity in part certain proofs of claim, (iii) reducing certain proofs of claim, (iv) reclassifying, in whole or in part, certain proofs of claim, as indicated on Exhibit 1 and (iv) allowing, as modified, the claims listed on Exhibit 1 annexed hereto, with proper classification as priority or unsecured general creditor claims, as indicated on Exhibit 1 all as more fully described in the Two Hundred Fifty-Sixth Omnibus Objection to General Creditor

1. Capitalized terms not otherwise defined herein shall have the meaning ascribed to them in the Motion.

Claims; and due and proper notice of the Two Hundred Fifty-Sixth Omnibus Objection to General Creditor Claims having been provided, and it appearing that no other or further notice need be provided; and the Court having found and determined that the relief sought in the Two Hundred Fifty-Sixth Omnibus Objection to General Creditor Claims is in the best interests of LBI, its estate, its customers and creditors, and all parties in interest and that the legal and factual bases set forth in the Two Hundred Fifty-Sixth Omnibus Objection to General Creditor Claims establish just cause for the relief granted herein; and after due deliberation and sufficient cause appearing therefor, it is

ORDERED that the relief requested in the Two Hundred Fifty-Sixth Omnibus Objection to General Creditor Claims is granted; and it is further

ORDERED that, pursuant to sections 502(b) of the Bankruptcy Code, the claims listed on Exhibit 1 that constitute Commissions Claims, Severance Claims, Hypo-Tax Claims, and Capped Claims are reduced, as set forth on Exhibit 1 in the column entitled “*Claim as Modified*” and in the row designated “(T)”, with prejudice, and allowed to the extent of such amounts; and it is further

ORDERED that, pursuant to sections 502(b), 506, and 507(a) of the Bankruptcy Code, the claims listed on Exhibit 1 that constitute Misclassified Claims are reclassified as set forth on Exhibit 1 in the column entitled “*Claim as Modified*”, with prejudice, and allowed to the extent of such priorities; and it is further

ORDERED that, pursuant to section 502(b) of the Bankruptcy Code, the portions of the claims listed on Exhibit 1 annexed hereto that constitute Equity Awards Claims and Insufficient Documentation Claims as indicated on Exhibit 1 attached hereto, are disallowed and expunged in their entirety with prejudice; and it is further

ORDERED that the portions of the claims listed on Exhibit 1 that constitute Accrued Equity Claims and Bonus Equity Claims are reclassified as equity interests, in amounts and with a level of priority to be determined, as indicated on Exhibit 1 attached hereto, with prejudice, and allowed in the amounts and priorities set forth on Exhibit 1 in the column entitled “*Claim as Modified*”; and it is further

ORDERED that this Court shall retain jurisdiction to hear and determine all matters arising from or related to the implementation and/or interpretation of this Order.

Dated: New York, New York
_____, 2014

UNITED STATES BANKRUPTCY JUDGE

EXHIBIT 1

IN RE LEHMAN BROTHERS INC., CASE No: 08-01420 (SCC) SIPA
TWO HUNDRED FIFTY-SIXTH OMNIBUS OBJECTION: EXHIBIT 1- EMPLOYEE CLAIMS

	NAME / ADDRESS OF CLAIMANT	CLAIM NUMBER	DATE FILED	ASSERTED AMOUNT**	CLAIM AS MODIFIED	COMM. CLAIM	MISCLASS. CLAIM	SEV. CLAIM	EQUITY AWARDS CLAIM	ACCRUED EQUITY CLAIM	DEF. COMP CLAIM	BONUS EQUITY CLAIM	CAPPED CLAIM	HYPOTAX CLAIM	INSUFF. DOC CLAIM
1	ACKERS, CLIFFORD BRYANT 40 PEAR TREE POINT ROAD DARIEN, CT 06820	7000214	12/14/2008	- (A) - (S) \$459,000.00 (P) - (U) \$459,000.00 (T)	- (A) - (S) - (P) \$459,000.00 (U) \$459,000.00 (T)		X								
2	BHUTANI, SARABJIT SINGH 3 TREGUNTER PATH, APT 5B BRANKSOME GRANDE MIDLEVELS HONG KONG CHINA	3268	2/2/2009	- (A) - (S) \$635,685.00 (P) - (U) \$635,685.00 (T)	- (A) - (S) \$10,950.00 (P) \$507,485.16 (U) \$518,435.16 (T) ¹		X	X						X	
3	BREWSTER, MICHAEL J. 269 WESTLAKE BLVD MAHOPAC, NY 10541	7001092	1/30/2009	- (A) - (S) \$190,125.00 (P) - (U) \$190,125.00 (T)	- (A) - (S) \$10,950.00 (P) \$71,937.29 (U) \$82,887.29 (T)	X	X								
4	BRITO, ROBERT M. 828 3RD STREET, PH3 MIAMI BEACH, FL 33139	4516	5/12/2009	- (A) - (S) \$15,183.30 (P) - (U) \$15,183.30 (T)	- (A) - (S) \$10,950.00 (P) \$4,233.30 (U) \$15,183.30 (T)		X								

1. The amount to be allowed for claim number 3268, listed in the column entitled “Claim as Modified,” reflects both amounts associated with items discussed in the Two Hundred Fifty-Fifth Omnibus Objection to General Creditor Claims and amounts associated with an additional Allowable Portion for expenses.

<p>(A) – ADMINISTRATIVE (S) – SECURED (P) – PRIORITY (U) – UNSECURED (T) – TOTAL CLAIMED</p>
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* Claim includes unspecified amounts (i.e., amounts not specified by the claimant, amounts listed in a foreign currency, unliquidated amounts and/or amounts listed as “unknown”, “\$0.00*”, “unascertainable”, “undetermined”, or where no dollar amounts were entered in the spaces provided on the proof of claim form), or is a customer claim reclassified to a general creditor claim, which, consistent with the general creditor claims register, is listed as unspecified even where the claimant listed a specific amount on the SIPC customer claim form.

** The values listed are the asserted values as they appear on the LBI general claims register as maintained by the Trustee’s claims agent, and do not necessarily reflect the caps set by the Secured and Priority Claims Reserve Order and Unsecured Claims Reserve Order.

	NAME / ADDRESS OF CLAIMANT	CLAIM NUMBER	DATE FILED	ASSERTED AMOUNT**	CLAIM AS MODIFIED	COMM. CLAIM	MISCLASS. CLAIM	SEV. CLAIM	EQUITY AWARDS CLAIM	ACCRUED EQUITY CLAIM	DEF. COMP CLAIM	BONUS EQUITY CLAIM	CAPPED CLAIM	HYPOTAX CLAIM	INSUFF. DOC CLAIM
5	CAZZOLI, RICCARDO 24 WEST 96TH STREET APARTMENT 3F NEW YORK, NY 10025	7001109	1/14/2009	- (A) - (S) \$191,798.00 (P) \$136,650.15 (U) \$328,448.15 (T)	- (A) - (S) - (P) \$180,000.00 (U) \$180,000.00 (T)		X		X					X	
6	CUNNINGHAM, PATRICK 4926 PERSHING AVE DOWNERS GROVE, IL 60515	34	12/8/2008	- (A) - (S) \$16,322.02 (P) - (U) \$16,322.02 (T)	- (A) - (S) \$10,950.00 (P) \$5,372.02 (U) \$16,322.02 (T) ²		X								
7	FLIEDNER, COREY 16 CREST HILL CT HUNTINGTON STATION, NY 11790	5194	5/29/2009	- (A) - (S) \$4,153.85 (P) \$55,282.87 (U) \$59,436.72 (T)	- (A) - (S) \$4,153.85 (P) \$39,807.70 (U) \$43,961.55 (T)			X							
8	GLISKER, GEORGE 139 EUSTON ROAD GARDEN CITY, NY 11530	7001532	5/14/2009	- (A) \$69,541.76 (S) - (P) \$69,541.76 (U) \$69,541.76 (T)	- (A) - (S) - (P) \$69,541.76 (U) \$69,541.76 (T)		X								
9	KANE, JEANNE 24 SCHERMERHORN STREET BROOKLYN, NY 11201	4509	4/17/2009	- (A) - (S) \$3,696.00 (P) \$151,200.00 (U) \$154,896.00 (T)	- (A) - (S) \$3,696.00 (P) \$130,919.43 (U) \$134,615.43 (T)			X							

2. The portion of claim number 34 which asserts a claim for Accrued Equity is currently subject to the Trustee's One Hundred Fifty-First Omnibus Objection to General Creditor Claims (ECF 9478). This portion of the claim is unaffected by this Two Hundred Fifty-Fifth Omnibus Objection to General Creditor Claims.

(A) – ADMINISTRATIVE
(S) – SECURED
(P) – PRIORITY
(U) – UNSECURED
(T) – TOTAL CLAIMED

* Claim includes unspecified amounts (i.e., amounts not specified by the claimant, amounts listed in a foreign currency, unliquidated amounts and/or amounts listed as “unknown”, “\$0.00*”, “unascertainable”, “undetermined”, or where no dollar amounts were entered in the spaces provided on the proof of claim form), or is a customer claim reclassified to a general creditor claim, which, consistent with the general creditor claims register, is listed as unspecified even where the claimant listed a specific amount on the SIPC customer claim form.

** The values listed are the asserted values as they appear on the LBI general claims register as maintained by the Trustee's claims agent, and do not necessarily reflect the caps set by the Secured and Priority Claims Reserve Order and Unsecured Claims Reserve Order.

	NAME / ADDRESS OF CLAIMANT	CLAIM NUMBER	DATE FILED	ASSERTED AMOUNT**	CLAIM AS MODIFIED	COMM. CLAIM	MISCLASS. CLAIM	SEV. CLAIM	EQUITY AWARDS CLAIM	ACCRUED EQUITY CLAIM	DEF. COMP CLAIM	BONUS EQUITY CLAIM	CAPPED CLAIM	HYPO-TAX CLAIM	INSUFF. DOC CLAIM
10	KENT, ELIZABETH AMANDA 111 EAST 85TH STREET APT. 23E NEW YORK, NY 10028	1851	1/28/2009	- (A) - (S) \$10,950.00 (P) \$12,848.10 (U) \$23,798.10 (T)	- (A) - (S) \$10,950.00 (P) \$9,146.18 (U) \$20,096.18 (T)			X	X						
11	LAZARES, NICHOLAS W. 255 ADAMS ST. MILTON, MA 02186	7002114	5/26/2009	- (A) - (S) - (P) \$8,625,000.00 (U) \$8,625,000.00 (T)	- (A) - (S) - (P) \$1,637,500.00 (U) \$1,637,500.00 (T)				X				X		
12	LUCAS, VINCENT GEOFFREY UNIT #1023 GREENWICH CLUB RESIDENCES NEW YORK, NY 10006	7001032	1/30/2009	- (A) - (S) \$167,123.00 (P) - (U) \$167,123.00 (T)	- (A) - (S) - (P) \$167,123.00 (U) \$167,123.00 (T)		X								
13	OOKA, TAMIKO LUMIERE DE MITA #203 2-1-41 MITA MINATO-KU TOKYO 108-0073 JAPAN	8001776	1/28/2009	- (A) - (S) - (P) UNSPECIFIED* (U) UNSPECIFIED* (T)	- (A) - (S) - (P) \$108,333.36 (U) \$108,333.36 (T)			X							X
14	OSGOOD, MARK 1218 COLONY PLAZA NEWPORT BEACH, CA 92660	8000018	12/2/2008	- (A) - (S) - (P) UNSPECIFIED* (U) UNSPECIFIED* (T)	- (A) - (S) - (P) \$800,000.00 (U) \$800,000.00 (T)							X			
15	PRESTON, GERAINT 75 WALL STREET, #22M NEW YORK, NY 10005	8001960	1/28/2009	- (A) - (S) - (P) UNSPECIFIED* (U) UNSPECIFIED* (T)	- (A) - (S) - (P) \$101,928.00 (U) \$101,928.00 (T)				X					X	

(A) – ADMINISTRATIVE
(S) – SECURED
(P) – PRIORITY
(U) – UNSECURED
(T) – TOTAL CLAIMED

* Claim includes unspecified amounts (i.e., amounts not specified by the claimant, amounts listed in a foreign currency, unliquidated amounts and/or amounts listed as “unknown”, “\$0.00*”, “unascertainable”, “undetermined”, or where no dollar amounts were entered in the spaces provided on the proof of claim form), or is a customer claim reclassified to a general creditor claim, which, consistent with the general creditor claims register, is listed as unspecified even where the claimant listed a specific amount on the SIPC customer claim form.

** The values listed are the asserted values as they appear on the LBI general claims register as maintained by the Trustee’s claims agent, and do not necessarily reflect the caps set by the Secured and Priority Claims Reserve Order and Unsecured Claims Reserve Order.

	NAME / ADDRESS OF CLAIMANT	CLAIM NUMBER	DATE FILED	ASSERTED AMOUNT**	CLAIM AS MODIFIED	COMM. CLAIM	MISCLASS. CLAIM	SEV. CLAIM	EQUITY AWARDS CLAIM	ACCRUED EQUITY CLAIM	DEF. COMP CLAIM	BONUS EQUITY CLAIM	CAPPED CLAIM	HYPO-TAX CLAIM	INSUFF. DOC CLAIM
16	SIECZKOWSKI, WALTER J. 30 CLUB DRIVE MASSAPEQUA, NY 11758	4698	5/22/2009	- (A) \$916,878.00 (S) - (P) \$916,878.00 (U) \$916,878.00 (T)	- (A) - (S) - (P) \$672,507.62 (U) \$672,507.62 (T)		X				X				
17	SULLIVAN, MARK L. 21 OVERHILL AVENUE RYE, NY 10580	7001064	1/30/2009	- (A) - (S) \$102,365.00 (P) - (U) \$102,365.00 (T)	- (A) - (S) \$10,950.00 (P) \$58,853.31 (U) \$69,803.31 (T)	X	X								
18	THAI, THANH HUNG BLOCK E, 28/F, THE MANHATTAN, 33 TAI TAM ROAD TAI TAM HONG KONG HONG KONG	7002047	5/27/2009	- (A) - (S) \$10,950.00 (P) \$526,003.86 (U) \$536,953.86 (T)	- (A) - (S) \$10,950.00 (P) \$382,166.59 (U) \$393,116.59 (T) ³									X	X
19	THOMAS ANDREW OLLQUIST PRIVATE EQUITY ACCOUNT 190 BEDELL AVENUE WEST HEMPSTEAD, NY 11550	7002344	5/31/2009	- (A) - (S) \$200,000.00 (P) - (U) \$200,000.00 (T)	- (A) - (S) \$10,950.00 (P) \$49,834.18 (U) \$60,784.18 (T) ⁴		X	X	X	X					

- The amount to be allowed for claim number 7002047, listed in the column entitled "Claim as Modified," reflects both amounts associated with items discussed in the Two Hundred Fifty-Fifth Omnibus Objection to General Creditor Claims and amounts associated with an additional Allowable Portion for unpaid severance.
- The amount to be allowed for claim number 7002344, listed in the column entitled "Claim as Modified," reflects both amounts associated with items discussed in the Two Hundred Fifty-Fifth Omnibus Objection to General Creditor Claims and amounts associated with an additional Allowable Portion for unpaid compensation.

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	NAME / ADDRESS OF CLAIMANT	CLAIM NUMBER	DATE FILED	ASSERTED AMOUNT**	CLAIM AS MODIFIED	COMM. CLAIM	MISCLASS. CLAIM	SEV. CLAIM	EQUITY AWARDS CLAIM	ACCRUED EQUITY CLAIM	DEF. COMP CLAIM	BONUS EQUITY CLAIM	CAPPED CLAIM	HYPOTAX CLAIM	INSUFF. DOC CLAIM
20	WANG, JANE (JIANGLING) 8212 LAUREL HEIGHTS LOOP LORTON, VA 22079	6075	7/27/2009	- (A) \$1,449.60 (S) \$1,449.60 (P) - (U) \$1,449.60 (T)	- (A) - (S) \$1,449.60 (P) - (U) \$1,449.60 (T)		X								
21	WAYNE, RICHARD N. 25 TRAILSIDE ROAD WESTON, MA 02493	7002113	5/26/2009	- (A) - (S) - (P) \$8,625,000.00 (U) \$8,625,000.00 (T)	- (A) - (S) - (P) \$1,637,500.00 (U) \$1,637,500.00 (T)				X				X		

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(T) – TOTAL CLAIMED

* Claim includes unspecified amounts (i.e., amounts not specified by the claimant, amounts listed in a foreign currency, unliquidated amounts and/or amounts listed as “unknown”, “\$0.00*”, “unascertainable”, “undetermined”, or where no dollar amounts were entered in the spaces provided on the proof of claim form), or is a customer claim reclassified to a general creditor claim, which, consistent with the general creditor claims register, is listed as unspecified even where the claimant listed a specific amount on the SIPC customer claim form.

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